STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155747	B. WING			07/22/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	ENTER			ERCER AVE UR, IN46733		
					011, 11140700		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0000		, , , , , , , , , , , , , , , , , , , ,		-			
1 0000							
	This visit was for	r a Recertification and	F0	000	This is Woodcrest Nursing		
	State Licensure S	Survey.			Center's Plan of Correction for		
					our annual survey conducted July 22, 2011.The plan of	ı on	
	Survey Dates: Ju	aly 18, 19, 20, 21, and 22,			correction is our credible		
	2011				allegation of		
					compliance.Preparation and/	or or	
	Facility Number:	000556			execution of this plan of correction in general, or this		
	Provider Number	r:155747			corrective action in particular		
	AIM Number: 10	00290130			does not constitute an admis		
					or agreement by Woodcrest		
	Survey Team:				Nursing Center of the facts alleged or conclusions set fo	rth in	
	Julie Wagoner, R	N, TC			the statement of deficiencies		
	Christine Fodrea	, RN			The plan of correction and		
	Tim Long, RN				specific corrective actions ar		
	_				prepared and /or executed in compliance with State and	ı	
	Census bed type:				Federal laws.		
	SNF/NF: 119						
	Total: 119						
	Census payor typ	oe:					
	Medicare: 09						
	Medicaid: 72						
	Other: 38						
	Total: 119						
	Sample: 24						
	These deficiencie	es also reflect State					
	findings cited in	accordance with 410 IAC					
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/22/2011
	PROVIDER OR SUPPLIEF		STREET A 1300 M	ADDRESS, CITY, STATE, ZIP CODE IERCER AVE TUR, IN46733	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	Quality review c 2011 by Bev Fau	ompleted on July 29, alkner, RN			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPL	ETED
	155747	1			07/22/2	011
		D. WINC		DDRESS CITY STATE ZIPCODE		
PROVIDER OR SUPPLIER						
REST NURSING CE	ENTER					
SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
resident; consult wand if known, notif representative or a when there is an a resident which respotential for requir significant change mental, or psychosocial statuconditions or clinical tertreatment significant in the psychosocial statuconditions or clinical tertreatment significant in alter treatment significant in adverse consequence form of treatment facility as specified. The facility must a resident and, if known in the significant in the	with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or us in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to use the resident from the d in §483.12(a). Ilso promptly notify the own, the resident's legal interested family member lange in room or roommate excified in §483.15(e)(2); or					
State law or regula	ations as specified in					
The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.						
Based on observation interview, the fact physician was not in skin condition was not effective medications were unavailable for 3	cility failed to ensure the stified timely of changes, when ordered treatment and when ordered e not given due to being residents	F0	157	be accomplished for those residents found to have been affected by the deficient practice? For Resident #24, the physician was notified of chain skin condition prior to surv. Resident #24 has RHC'd. For Resident #69, medications w	ne nges ey.	08/21/2011
	PROVIDER OR SUPPLIER REST NURSING CI SUMMARY S (EACH DEFICIEN REGULATORY OR A facility must immoresident; consult wand if known, notifice representative or a when there is an aresident which respotential for requiring significant changemental, or psychosocial statuconditions or clinical alter treatment significant changemental, or psychosocial statuconditions or clinical alter treatment significant changemental, or psychosocial statuconditions or clinical alter treatment significant changemental, or psychosocial statuconditions or clinical alter treatment significant changement and it is a change in resident and, if known in the service in the service of t	PROVIDER OR SUPPLIER REST NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested	PROVIDER OR SUPPLIER REST NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to ensure the physician was notified timely of changes in skin condition, when ordered medications were not given due to being unavailable for 3 residents	PROVIDER OR SUPPLIER REST NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident singly member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to ensure the physician was notified timely of changes in skin condition, when ordered medications were not given due to being unavailable for 3 residents	DENOTIFICATION NUMBER: 155747 A BUILDING 3. WING	PROVIDER OR SUPPLIER REST NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PERCEDED BY FULL RIGILATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident which resident shophysician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to alter treatment significantly (i.e., a need to alter treatment significantly (i.e., a need to alter treatment significantly (i.e., a need to silecontinum or or of treatment) or a decision to transfer or discharge the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.12(a). The facility must also promptly notify the resident from the facility must also promptly notify the resident from the facility must also promptly notify the resident fagliate the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to ensure the physician was notified timely of changes in skin condition, when ordered medications were not given due to being unavailable for 3 residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CON	NSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMB	SER:	A. BUILDI	NG	00	COMPL		
		155747		B. WING			07/22/2	011	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
	NO VIDEN ON DOLLER					RCER AVE			
WOODC	REST NURSING CE	ENTER		[DECATU	JR, IN46733			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIEN	ICIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED	BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFO	RMATION)	7	TAG	DEFICIENCY)		DATE	
	*	1. LSC IDENTIFYING INFO				physician notified of missed medications. Resident #69 wischarged to home. For Resident and interest medications are being administered, physician notified of missed medication. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? In an effort to identify any other applicable residents, the MA all residents was reviewed to identify and other missed medications. No additional residents were identified to himissed medications. All residents were identified a checked for changes in skin condition and the need to not the physician. No other residents were identified. What measures will be put into play what systemic changes will be made to ensure that the definition and the conducted RN's and LPN's on August 1 2011. The revised Wound Copolicy will be reviewed along the revised Order and Receip Drugsd From the Pharmacy policy. Timely notification to the physician for missed medications and time notification will be discussed. How the corrective action(s)	was ident re in s.2. the elected R for one dents and tiffy dents ce or one cient for all 8, are with pt of the core of the cor	l	
						be monitored to ensure the deficient practice will not rec	ur,		
						i.e., what quality assurance	•		
FORM CMS-2	.567(02-99) Previous Versio	ns Obsolete	Event ID: 0	JLM11	Facility II	D: 000556 If continuation s	heet Pa	ge 4 of 81	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155/4/	B. WIN			07/22/2	U11
	PROVIDER OR SUPPLIER			1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	·		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	201	DATE
	conducted on 07/A.M 11:30 A.M. Nursing indicated pressure ulcer on The clinical recordive eviewed on 07/1 resident was adm 01/12/05 with dialimited to diabeted disease. Review of a nurse	rd for Resident #24 was 9/11 at 10:50 A.M. The nitted to the facility on agnosis, including but not es and peripheral vascular es note, dated 06/15/11 at			programs will be put into place. The night shift charge nurse audit all MAR weekly to ensure ordered medications are mist. This will be ongoing times 6 months with results to QA. So assessments will done week the charge nurse on each has and the charge nurse will not the physician when there is a change in condition of the skin. Physician notification a new orders will be document the nurse's notes which will be read and audited by the DON ADON M-F ongoing with rest to QA times 6 months. Skin assessments will be assigned weekly by the DON and the assigned charge nurse will in DON weekly of completion ongoing times 6 months with results to QA.	will ure no sed. Skin ly by ull tify a nd ted in toe N and ults d otify	
	0.33 A.M., indica	ated the following:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

If continuation sheet

Page 5 of 81

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
		155747	B. WIN			07/22/2	011
NAME OF	PROVIDER OR SUPPLIEI	!! }	!	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ERCER AVE		
	REST NURSING C			DECAIL	UR, IN46733		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG	ŧ	ilateral lower extremities)		IAG	,		DAIL
	`) warm to touch denies					
	` `	l. has BLE edema 3 +					
	1 ^	n legs being elevated					
	1 ~	ight. Oncoming nurse					
	_	she will call the MD					
	(medical doctor)						
		, , , , , , , , , , , , , , , , , , ,					
	A subsequent nu	rse's note, dated 06/15/11					
	1 ^	M.) indicated the					
	,	legs cont (continues) to be					
	_	or et warm to the touch.					
	(Physician's nam	ne)'s office notified.					
	1 ` *	ne) out of office today.					
	May call tomorr	ow to see if (physician's					
	name) has any n						
	A nurse's note, d	lated 06/16/11 at 12:35					
	P.M., indicated t	the physician was					
	updated. There	was no physician's order					
	given regarding	Resident #24's legs.					
	There was no fu	rther note or assessment					
		legs in the progress notes					
		11:00 A.M., which					
		ident's legs were still					
	· ·	warm to touch with 3+					
		The on call physician was					
	notified.						
	_	sing progress note, dated					
		0 noon, indicated the on					
	1	d not want to give any					
	orders regarding	Resident #24's legs but					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (FACH OF THE PROPERTIES OF THE PROPERTY OF THE PROPERTIES OF THE PROPERTIES OF THE PROPERTIES OF THE P	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
MAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER IS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION) TAG REGULATORY OR ISC IDENTIFYING INFORMATION) TAG resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with			155747	B. WIN			07/22/2	:011
CAU III SUMMARY STATEMENT OF DEFICIENCIES DECATUR, IN46733	NAME OF P	PROVIDER OR SUPPLIER			1			
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with	WOODO		TNITED		1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with					DECAI	UR, IN46733		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with								
preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		`				CROSS-REFERENCED TO THE APPROPRIA	TE	1
to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with	IAG		,	+	IAG	DEFICIENCE!)		DATE
resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		•	•					
A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		_	• •					
1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		resident in his of	fice.					
1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		A 						
been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		0.0						
be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		· ·						
Cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with								
Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		-	-					
indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		cellulitis in her id	ower extremities.					
indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		Numaina mataa fin	nom 06/20/11 06/20/11					
antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		_						
remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with			•					
A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with			_					
A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with		-	follen, and warm to					
A.M., indicated the physician was notified of the resident's continued cellulitis with		toucn.						
A.M., indicated the physician was notified of the resident's continued cellulitis with		A nursing note d	lated 06/29/11 at 10:00					
of the resident's continued cellulitis with								
		•						
no improvement and a decrease in the								
resident's oxygen saturation level and		-						
some shortness of breath. The resident								
was sent to the local emergency room and								
returned with orders to change the			G S					
antibiotic to Levaquin.			· ·					
antiologe to Devagam.		antiblotic to Levi	ичин.					
Interview with the Director of Nursing		Interview with th	ne Director of Nursing					
regarding the delay in obtaining initial			· ·					
treatment for the resident's cellulitis and			-					
also in notifying the physician of the need								
to change treatment due to no								
improvement in the resident's cellulitis on		_						
07/22/11 at 11:00 A.M., indicated there		-						
was no reason for the delay and lack of								

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPI		
ANDTEAN	or condition	155747	1	LDING		07/22/2	
		100747	B. WIN			0112212	.011
NAME OF I	PROVIDER OR SUPPLIER	4		1	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING C	ENTER		1	ERCER AVE UR, IN46733		
				L	OIX, IIX+0733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	N CE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
	nursing follow u	p with the physician.					
	on 07/19/11 at 1: was noted to have a golf ball on her had apparently p resident was note to both lower ext edema increased white socks. Bo noted to be redde The resident was left foot was more #5, indicated he	gs and feet were assessed at 15 P.M. The resident re an open area the size of a left heel where a blister opped. In addition, the red to have bilateral edema tremities and feet. The above the resident's tight the shins and feet were rened and had scaly skin. It is noted to wince when her red. Nursing staff, LPN ar feet and shins did not che and did not look as red before antibiotic					
	7/19/20211 at 3:4 diagnoses includ diabetes, congest pulmonary edem A current physic Scopolamine (a tibeen ordered 5/1 administered 0.2 hours through a predication for p	a. ian's order indicated medication for pain) had					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	A review of the						
	Administration I	Record (MAR), dated					
	7/2011, revealed	initials of nurse					
	administering Sc	copolamine were circled					
	on 7/16 at 8 p.m	.; and 7/17/2011 at 6 am,					
	noon, and 8 p.m.	On the back of the					
	MAR, under the	date 7/16/2011, the					
	record indicated	Scopolamine was not					
	given as there w	as no supply on hand.					
	A review of the	Medication					
	Administration I	Record (MAR), dated					
	7/2011, revealed						
	· ·	eurontin were circled on					
		e, 7/15- noon and 8 p.m.					
	_	and 8 p.m. doses; 7/17-					
		8 p.m. doses; and 7/18-8					
	· ·	oses. On the back of the					
		date 7/14 and 7/15/2011,					
		ated medications were not					
	~	as no supply on hand and					
	1	nwaiting family and					
	nospice to supply	y the medication.					
	Intervious suith 41	a Director of Nameine on					
		ne Director of Nursing on					
		P.M., indicated the					
		e available in the EDK					
	1	g kit) or from the hospital					
	1 ^	nould have been given.					
		ed the physician should					
	have been notific	ed of any missed doses.					
		's record was reviewed					
	7/20/2011 at 2:4	5 p.m. Resident #107's					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE COMPI 07/22/2	LETED	
	PROVIDER OR SUPPLIER			1300 ME	DDRESS, CITY, STATE, ZIP CODE ERCER AVE JR, IN46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	1	led but were not limited to lisease, congestive heart ession.					
	1	ian's order dated atted Humulin N 30 units addred 5/1/2011.					
	1	der dated 6/20/2011 Novolin N in place of					
	6/2011 revealed administering in a.m. were circled MAR, under the at 8:00 a.m., the	Record (MAR) dated initials of nurse sulin on 6/20/2011 at 8:00 d. On the back of the date and time 6/20/2011 record indicated Novolin not given as there was no					
	7/2011 revealed administering in a.m. were circled MAR, under the 8:00 a.m., the re-	Record (MAR) dated initials of nurse sulin on 7/8/2011 at 8:00 d. On the back of the date and time 7/8/2011 at cord indicated Novolin N given as there was no					
	A document production Administrator or	vided by the n 7/20/2011 at 10:00 a.m.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED (2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	of the need for H The pharmacy st was willing to su communicate wi 6/20/2011, causi Additionally, on had not ordered t missed dose. In an interview 7 the Administrato should have been were not administ A current policy 3/11 titled Physic	armacy had been notified fumulin N on 6/17/2011. Tocked Novolin N, and abstitute, but did not the facility untiling a missed dose. To 7/8/2011, the facility the insulin causing a stered at the physician in notified if medications attered as ordered. Idated 2/9/00 and updated the physician was to be notified if all not be given.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	IERCER AVE		
WOODCI	REST NURSING CE	ENTER		l	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0244		r family group exists, the					
SS=E	•	to the views and act upon					
		d recommendations of illes concerning proposed					
		onal decisions affecting					
	resident care and						
		ation, interview and	F0	244	1. What corrective action(s) v	vill	08/21/2011
		e facility failed to			be accomplished for those		, , , , , , , , , , , , , , , , , , ,
	· · · · · · · · · · · · · · · · · · ·	olve grievances expressed			residents found to have beer	1	
	•				affected by the deficient		
		il meetings related to			practice?All residents attend	•	
	-	d extended wait time to			the group meeting along with other residents were interview		
		ing room following			by the Activities Coordinator, so staff could respond to their issues		
	meals. This actua	ally affected 7 of 11					
	residents who att	ended the group meeting			in regards to noise. All MAR		
	(Resident #201, 2	202, 203, 204, 207, 208,			were reviewed by the night shift		
		esident interviewed			charge nurse to see if any		
		oup meeting. (Resident			medications could be given v		
	#78)	oup meeting. (Resident			morning med pass and not d	uring	
	#/0)				sleeping hours. A new pill		
					crusher was purchased to eliminate unnecessary noise	for	
	Findings include	:			each cart. A CNA will	101	
					be assigned from each wing	to	
	1. During group	meeting on 7/19/2011 at			return residents to their room		
	9:30 a.m., 7 of 11	l residents (Residents			from the dining room in a tim	ely	
	#201, 202, 203, 2	204, 207, 208 and 210)			fashion.2. How other resider		
	present expressed	d concern over the			having the potential to be affor		
		at night, indicating noise			by the same deficient practic		
	at night was a cu	_			be identified and what correct action(s) will be taken?In an		
	at hight was a cu	Trent problem.			to identify any other applicab		
		1 4 6 11 4 6			residents affected by noise a		
		dent Council Minutes for			night or waiting too long in th		
		ruary 2011 indicated			dining room, random intervie		
	residents had exp	pressed a concern			were conducted to ensure th	ere	
	regarding noise a	t night. The concern had			are no issues with noise or		
	been noted and g	iven to the Director of			waiting time following meals to return to room. The audit revealed there are no current		
	-	onse and resolution.					
	<i>3</i> 3-1-5p.				issues in regards to excessiv		
			1		1	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155747	B. WIN			07/22/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				ERCER AVE	
WOODC	REST NURSING CE	ENTER		1	UR, IN46733	
	_	TATEMENT OF DEFICIENCIES		ID	,	(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE
1710				1710	noise at night. An audit was	DATE
		Resident/ Family Council			conducted on various days	
	1 ^	esponse, dated 2/8/2011,			including breakfast, lunch, ar	nd
		eern regarding noise at			dinner. No issues were ident	
	night was referre	d to the Director of			as all residents were served	
	Nursing with a re	esolution requested by			within 30 minutes of ordering	
	2/28/2011. The r	response indicated the			all residents requesting to re	
		vening Supervisor and			to their room were returned v	
	_	were made aware of the			5 minutes of request. Results be shared at the September	S WIII
		regarding noise at night.			Residents Council Meeting.3	
					What measures will be put in	
	1	sted to have quiet decor			place or what systemic chan	
		nonitoring or further			will be made to ensure that t	- 1
	investigation was	s indicated as being			deficient practice will not rec	ır?All
	completed.				concerns from Resident Cou	
					will be forwarded to the corre	
	In an interview o	on 7/20/2011 at 8:30 a.m.,			manager to be resolved with	
		licated noise in the			hours. When the concern ca	
					be resolved within 48 hours, managers will discuss the	uie
	l lacility at hight w	vas still a problem.			concern with the administrate	or
					The concerns and resolution	
		meeting on 7/19/2011 at			be discussed at each Reside	
	9:30 a.m., 6 of 11	1 residents indicated there			Council meeting and concerr	ns
	was not enough s	staff to get residents out			will be resolved at the next	
	of the main dinin	ng area after they finished			meeting with the	
		n long wait times.			minutes reflecting the concer	
		<i>5</i>			resolved. The Grievance Cor	
	Δ review of Pegi-	dent Council minutes			Report Policy will be reviewe the all staff in-service on Aug	
					18, 2011. Excessive noise at	· I
		owing: In January 2011,			night will be discussed at the	
		ng the meeting had			in-service and a CNA from ea	
	1 ^	ern the wait time was too			wing will be assigned to retu	
	long after meals t	to get out of the dining			residents form meals on a da	· 1
	room. The respor	nse to the Council in			basis, which will also be revi	
	1	ed walkie talkies had			at the all staff in-service. 4.	
	1 *	n March 2011, residents			the corrective action(s) will b monitored to ensure the defice	
	1 *	he CNAs were not			practice will not recur, i.e., w	
	1 -				quality assurance programs	
	Coming to the Ma	ain Dining Room to				
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	0ULM11	Facility 1	ID: 000556 If continuation sl	neet Page 13 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 07/22/2 (ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	dining. The responder April from the Dishe would talk to residents again at CNAs not coming Room to assist response after eating Director of Nurse Family Council I dated 5/11/2011, assigned to the diresidents back to response did not monitoring to assigned to the diresidents. In July addressed the continues to return to Main Dining Room responded with a issue and monitor During an observable tween 11:20 and noted wait staff with their rooms will a current policy updated 3/2011 to Report Policy inconcerns would be assisted to their rooms will respond to the concerns would be a served to their rooms will respond to the concerns would be a served	sure staff were assisting 2011, residents again neern of extended wait rooms after dining in the om. The Dietary Manager plan for auditing the ring the dining area. Vation on 7/21/2011 m and 12:30 p.m., it was were returning residents			be put into place: The Activity Coordinator will interview 10 residents from each wing in regards to noise and excess wait time in the dining room monthly times 6 months with results to QA.All minutes from Resident Council will be given the administrator following the meeting. The administrator monitor all concerns to ensure they are addressed within 48 hours following the meeting ongoing with results to QA times from the following the meeting ongoing with results to QA times following the meeting ongoing with results to QA times following the meeting ongoing with results to QA times following the meeting ongoing with results to QA times following the meeting ongoing with results to QA times for months.	ive m the en to le will re	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155747	B. WIN	G		07/22/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	ENTER		1	ERCER AVE UR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0246 SS=D	services in the faci accommodations of	right to reside and receive ility with reasonable of individual needs and ot when the health or safety					
	of the individual or endangered. Based on observation interview, the fact dining table of properties and the fact that the fact to the facility on the resident was meals on 7/20/11 at 11:40. Lounge (assist dimed) as table with no feed herself at all meal, a staff persident was endal, a staff persident was meals on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was meals, a staff persident was meals on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was meals on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was meals on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all meal, a staff persident was means on 7/20/11 at 12 at a table with no feed herself at all means of 7/20/11 at 12	other residents would be ation, record review and cality failed to provide a roper height to enable 1 21 residents observed to aple of 24. inical record was //11 at 11:15 A.M. The the resident was admitted 2/5/08. observed during two at 12:00 P.M., and A.M., in the Tea Room ning room). 2:00 P.M., the resident sate staff present and did not at one point during the on came to the table and bite of her meal. The	F0	246	1. What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? A table of adjustable height is ordered for each of lounges. A bedside table of adjustable height will be utilize for Resident #51 until the table arrive. Care plan for Resident #51 has been updated to refles her dietary needs and assistant needs. 2. How other resident having the potential to be affected by the same deficient practice be identified and what correct action(s) will be taken? In an to identify any other applicable residents, the CDM audited a residents eating in lounges of dining room for appropriate to height. One other resident we found but refused to change tables and not eat with her friends. This was care planned. 3. What measures we be put into place or what syschanges will be made to ensithat the deficient practice does not recur? The CDM will mon	e the zed cles nt ect ance is ected e will ctive effort le all r able vas	08/21/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
		I	B. WIIV		DDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8			ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wheelchair and v	was at eye level with the			all residents upon admission	for	
	table and was un	able to see inside the			appropriate table height.	- l- l -	
	bowls her food v	vas brought in.			Residents needing a lower to will be placed at the new	abie	
		C			adjustable height tables.4.	łow	
	On 7/21/11 at 11	:40 A.M., the resident			the corrective action(s) will b		
		lifferent table than on			monitored to ensure the defic		
		seated next to a CNA			practice will not recur, what		
					quality assurance programs		
		ally assisting another meal. Resident #51's			be put into place?The CDM evaluate all residents upon	WIII	
					admission for appropriate tal	ole	
	1 ^	brought out in five			height ongoing with results to		
	_	nd placed before her. The			times 6 months.		
		ed several bites of food					
	after verbal cues	by the CNA. The					
	resident eye line	was right at the base of					
	the table and she	was unable to see inside					
	the bowls of foo	d.					
	An interview wi	th CNA #5 on 7/21/11 at					
	11:55 A.M., indi	cated the Tea Room					
	Lounge used to l	nave a lower table before					
	the floor was red	lone, around Christmas					
		ce then the lower table					
	1 -	dining room. CNA #5					
		ad tried using a TV tray					
	1	51 but she would upset					
		trying to feed herself.					
	1						
	CNA #5 indicated the resident is to be						
		ood and sometimes					
	requires assist to	eat.					
	An intervious wis	th the Director of Nursing					
		at 1:25 P.M., indicated					
		any information about					
	the table height j	problem for Resident #51					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
NAME OF F	AD CLUBED OD GUIDDUED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		1300 M	ERCER AVE		
	REST NURSING CI				UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION DATE
mo		staff should have been		1710	·		DATE
	using a bedside t						
	using a bedside t	able.					
	Δ review of the r	resident's care plan of					
		for inadequate nutrition					
		ident will feed self with					
	set up help and a	ssist ii lieeded.					
	3.1-19(w)(5)						
	3.1 17(W)(3)						
F0250		rovide medically-related					
SS=D	social services to attain or maintain the						
		e physical, mental, and being of each resident.					
		ation, record review, and	F0	250	What corrective action(s)	will	08/21/2011
		cility failed to develop a	10230	be accomplished for those		00/21/2011	
	•	ement program for			residents found to have been		
	_	viors for 1 of 7 residents			affected by the deficient practice?Resident #25- Beha	avior	
		aviors in a sample of 24			log was reviewed and compl		
	(Resident #25).	aviors in a sample of 24			when resident displays		
	(Resident #25).				aggressive behaviors, a care		
	Findings include				was implemented to address		
	i mamas merade	•			aggressive behaviors and other behavior issues.2. How other		
	1 During the ini	itial tour of the facility,			residents having the potentia		
	_	/18/11 between 10:30			be affected by the same defi		
		M., the Director of			practice will be identified and		
					what corrective action(s) will taken?In an effort to identify		
	Nursing indicated Resident #25 was confused, ambulated independently, wandered throughout the day, and was				applicable residents, Social	- 3	
					Service coordinator reviewed		
	_	She indicated the			behavior logs and implement		
		e to complete activities of			an aggression care plan with interventions if needed.3. W		
		cues and minimal			measures will be put into pla		
					what systemic changes will b		
	assisiance. Durii	ng the tour of the facility,				ľ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155747	A. BUII B. WIN			07/22/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ME OF PROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING C	ENTER			UR, IN46733		
					O11, 11440700		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	,	-:	DATE
		s observed ambulating in			made to ensure that the defi practice does not recur?Soc		
	1 *	was noted to follow or be			Services conducted an all st		
	invited to follow	various staff members			in-service on August 18, 201	l1. and	
	who were worki	ng on the unit. The			Identification of behaviors,		
	resident was not	ed to follow them for a			completion of behavior logs,		
	few minutes and	then wander off and			interventions for behaviors v		
	approach a diffe	rent staff member.			discussed. Behavior Health		
					AMH will conduct a more in- behavioral management	uepin	
	The clinical reco	ord for Resident #25 was			in-service for all staff on Aug	just	
		19/11 at 1:00 P.M. The			26.4. How the corrective	•	
		nitted to the facility, on			action(s) will be monitored to		
		•			ensure the deficient practice		
		agnosis, including but not			not recur, what quality assur	ance	
	· ·	eimer's dementia and			programs will be put into place?Social Services will m	onitor	
	depressive disor	der.			behavior logs weekly for 6	ioriitoi	
					months with results to QA.		
	The most recent	Minimum Data Set			DON/ADON will read nurses	3	
	(MDS) assessme	ent for Resident #25,			notes M-F, and inform Socia		
	completed on 05	5/31/11, indicated the			Services of any noted behav		
	resident did not	display any behavioral			This will be done M-F, ongoi with results to QA times 6	ing	
	issues, was inde	pendently ambulatory,			months.		
	1	pendently, and required					
	1 ^	ssistance for dressing,					
		e, and toileting needs.					
	personal hygiene	, and tonething needs.					
	The heelth sere	plans for Resident #25,					
	1	·					
		11, indicated a plan to					
	1	lent's wandering behavior					
	with interventions focused on maintaining her safety by knowing her whereabouts.						
	There was one in	ntervention regarding					
	providing diversional activities and rest						
	periods. There v	was no plan to address any					
	other behavioral	_					

AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155747 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE O COMPLETED 07/22/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733 (X5) COMPLETION COMPLETION 1300 MERCER AVE DECATUR, IN46733 (X5) COMPLETION COMPLETION COMPLETION COMPLETION DATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE 1300 MERCER AVE DECATUR, IN46733 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733 (X5) PREFIX PREFIX COMPLETION COMPLETION	AND PLAN	OF CORRECTION		A. BUI	LDING	00	1	
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER 1300 MERCER AVE DECATUR, IN46733 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION			133747	B. WIN			0112212	
WOODCREST NURSING CENTER DECATUR, IN46733 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	NAME OF I	PROVIDER OR SUPPLIER			1			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	WOODC	REST NURSING CE	-NTFR		1			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION						O11, 111-10700		77.5
CROSS-REFERENCED TO THE APPROPRIATE								
		`				CROSS-REFERENCED TO THE APPROPRIA	TΕ	
A physician's order, dated 04/26/11,								
indicated an order for the resident to be		1						
evaluated by a psychologist regarding her								
increase in aggressive behaviors. Review								
of the psychologist's report, completed on		""						
04/27/11, indicated the direct care staff		1						
had noted an increase in physically		1						
aggressive behaviors towards staff and								
other residents.			Total to Wards Start and					
		other residents.						
On 07/20/11 at 12:30 P.M., Resident #25's		On 07/20/11 at 1	2:30 P.M. Resident #25's					
husband was noted to be preparing the			· · · · · · · · · · · · · · · · · · ·					
resident to go out of the facility. On			1 1 0					
07/20/11, in the afternoon and on		1	•					
07/21/11 in the A.M., Resident #25 was		· ·						
not observed in the facility.								
			,					
Review of a nursing progress note, dated		Review of a nurs	ing progress note, dated					
07/20/11 at 10:30 A.M., indicated the								
physician had given an order to transfer			-					
the resident to an inpatient psychiatric		the resident to an	inpatient psychiatric					
hospital due to increased agitation.								
			-					
Nursing notes, dated 07/14/11 - 07/20/11,		Nursing notes, da	ated 07/14/11 - 07/20/11,					
indicated there were notes dated 07/15/11		indicated there w	vere notes dated 07/15/11					
at 1430 (2:30 P.M.) indicating the		at 1430 (2:30 P.1	M.) indicating the					
resident was "pacing the hall. Res not		resident was "pac	cing the hall. Res not					
easy to redirect. Res got agitated easy.		easy to redirect.	Res got agitated easy.					
Res up several times during meals asking		Res up several tii	mes during meals asking					
what she should do or where she should		what she should	do or where she should					
be." There were three notes, all dated		be." There were	three notes, all dated					
07/17/11, and timed as 8:30 A.M., 11:20		07/17/11, and tim	ned as 8:30 A.M., 11:20					
A.M., and 2200 (10:00 P.M.), indicating		A.M., and 2200 ((10:00 P.M.), indicating					
the resident was attempting to hit staff		the resident was	attempting to hit staff					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155747	B. WIN			07/22/20)TT
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	ERCER AVE		
WOODC	REST NURSING CI	ENTER		DECAI	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		was attempted and had					
	*	sidents and called them					
		ney were talking too					
	I	ere no other notes to					
		lent had exhibited any					
	other aggressive	and/or agitated					
	behaviors.						
	Review of a Beh	avior Log summary for					
	Resident #25 for	July 2011 indicated there					
	was one physical	lly abusive behavior					
	during a shower	on 07/1/11, two					
	physically abusiv	ve behaviors documented					
		e behavior of transferring					
		on 07/12/11, a restless					
		ented on 07/13/11, a					
		ve behavior documented					
		three behaviors noted on					
	07/17/11. Of the						
		en involved meal and/or					
	snack time.	on myorved mear and or					
	Shack time.						
	 Interview with th	ne Social services					
		1/11 at 1:50 P.M.,					
		s aware the resident was					
		he did not know any					
	· ·	•					
	_	tion regarding Resident					
	#25's transfer to	the psychiatric hospital.					
		A 1					
		ne Administrator and the					
		ing on 07/21/11 at 2:00					
	· ·	he resident's wandering					
		d she was becoming					
	increasingly agg	ressive with care needs so					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155747	B. WING		07/22/2011	
NAME OF B	DOWNER OF CHIRD IED		STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	<u>-</u>	1300 M	ERCER AVE		
	REST NURSING C			UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	it was decided by	-				
		nd the resident's family to				
		red to see if there was				
	-	ald be done regarding her				
		riors and increased				
	wandering.					
	3.1-34(a)					
F0279	A facility must use	the results of the				
SS=D		velop, review and revise the				
	resident's comprel	nensive plan of care.				
	The facility must d	evelop a comprehensive				
	<u>-</u>	resident that includes				
		tives and timetables to meet				
		al, nursing, and mental and				
		Is that are identified in the				
	comprehensive as	sessment.				
	The care plan mus	st describe the services that				
	•	d to attain or maintain the				
		practicable physical,				
		osocial well-being as				
		83.25; and any services that				
		e required under §483.25 ed due to the resident's				
	•	under §483.10, including the				
		tment under §483.10(b)(4).				
	Based on record	review and interview, the	F0279	What corrective action(s)	will 08/21/2011	
	facility failed to	develop health care plans		be accomplished for those		
	-	inence needs or abusive		residents found to have beer affected by the deficient	1	
		24 residents reviewed		practice?For Resident #25 a	care	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155747	B. WIN	G		07/22/2	011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF I	NO VIDEN ON SOLVER				ERCER AVE		
WOODC	REST NURSING CE	ENTER		DECAT	UR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for care plan dev	elopment in the sample			plan was implemented for		
	of 24. (Residents	#10, Resident #25)			aggressive behaviors by Soc Services with interventions.	ciai	
					Resident #25 was scheduled	l for a	
	Findings include	:			significant change with MDS		
					Resident #10, A care plan ar		
	1. During the ini	tial tour of the facility,			toileting program was		
	~	/18/11 between 10:30			implemented after completio		
		M., the Director of			a 7 day diary. Resident was placed on a toileting progran		
		d Resident #25 was			occasionally incontinent of b		
	~	ated independently,			and totally incontinent of		
	ĺ	hout the day, and was			bladder. 2. How other reside		
	ı	• .			having the potential to be aff		
	anxious at times.				by the same deficient practic		
	m 1 1	1.C. D. :1			be identified and what correct action(s) will be taken?All	cuve	
		rd for Resident #25 was			residents with an aggressive		
		9/11 at 1:00 P.M. The			behavior be audited by Socia		
		nitted to the facility, on			Services to ensure a care pla		
		agnosis, including but not			in place to address aggressi		
	limited to, Alzhe				behaviors and the need for a significant change with MDS		
	depressive disord	ler.			residents on an incontinence		
					program are being assessed		
	The most recent	Minimum Data Set			the restorative nurse for		
	(MDS) assessme	nt for Resident #25,			appropriateness of program,		
	completed on 05/	/31/11, indicated the			assessment, care plan to ref needs, correct plan on CNA	lect	
	resident did not d	lisplay any behavioral			assignment sheet, and MDS		
	issues, was indep	endently ambulatory,			nurse will monitor the need f		
	_	endently, and required			change with the		
	_	sistance for dressing,			toileting program.3. What		
		, and toileting needs.			measures will be put into pla what systemic changes iwll t		
	1	,			make to ensure that the defi		
	A nhysician's ord	ler, dated 04/26/11,			practice does not recur?All		
		er for the resident to be			nurses' notes and 24 hour re	port	
		sychologist regarding her			sheets will be read by		
					DON/ADON on M-F. Aggres		
		ssive behaviors. Review			behaviors will be reported to SS.Restorative nurse will		
	of the psychologi	ists report, completed on			55.Nestorative nurse will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155747 07/22/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 MERCER AVE WOODCREST NURSING CENTER DECATUR, IN46733 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 04/27/11, indicated the direct care staff implement a bowel/bladder care plan based on the 7 day diary had noted an increase in physically which will be done upon aggressive behaviors towards staff and admission, quarterly, and with any other residents. change in condition. New forms were implemented and in serviced on August 18, 2011.4. Nursing notes, dated 07/14/11 - 07/20/11 How the corrective action(s) will indicated there were notes, dated 07/15/11 be monitored to ensure the at 1430 (2:30 P.M.), indicating the deficient practice will not recur, resident was "pacing the hall. Res not what quality assurance programs will be put into place? Weekly, the easy to redirect. Res got agitated easy. restorative nurse will bring the Res up several times during meals asking bowel and bladder flow sheets to what she should do or where she should the care plan meeting and the be." There were three notes, all dated Restorative nurse/ADON will check accuracy of the flow sheets 07/17/11 and timed as 8:30 A.M., 11:20 with the care plan and the CNA A.M., and 2200 (10:00 P.M.), indicating assignment sheet. This will be the resident was attempting to hit staff ongoing with results to QA times 6 months. All nurses notes and when redirection was attempted and had 24 hour report sheets will be read yelled at other residents and called them M-F by the DON/ADON, they will names because they were talking too notify SS of any aggressive loudly. There were no other notes to behaviors. This will be ongoing indicate the resident had exhibited any with results to QA times 6 months. Whenever SS is notified other aggressive and/or agitated they will inform MDS nurse of an behaviors. aggressive behavior. MDS will check for aggressive behavior Review of a Behavior Log summary for care plan and will initiate a significant change if appropriate. Resident #25 for July 2011 indicated there This will be ongoing times 6 was one physically abusive behavior months. during a shower on 07/1/11, two physically abusive behaviors documented on 07/12/11, one behavior of transferring another resident on 07/12/11, a restless behavior documented on 07/13/11, a physically abusive behavior documented on 07/14/11, and three behaviors noted on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

If continuation sheet Page 23 of 81

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155747	B. WIN			07/22/20)11
NAME OF F	PROVIDER OR SUPPLIER	L		1	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING C	ENTED		1	ERCER AVE UR, IN46733		
					UR, IN40733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION DATE
IAG	07/17/11. Of the		+	IAG		+	DAIL
		en involved meal and/or					
	snack time.	en mvorved mear and/or					
	snack time.						
	The beetth come of	along for Davidant #25					
	_	plans for Resident #25,					
		11, indicated a plan to					
		ent's wandering behavior as focused on maintaining					
		•					
		owing her whereabouts.					
		itervention regarding					
	-	ional activities and rest					
	-	vas no plan to address any					
		issues, such as physical					
	abusive behavior	S.					
	2 Duning the ini	itial town of the facility					
	_	itial tour of the facility					
		/18/11 between 10:30					
		M., the Director of					
	_	d Resident #10 was					
	_	ed maximum staff					
		tivities of Daily Living					
	, , , ,	s incontinent of her					
		der and was toileted by					
	staff.						
	The eliminal mass	rd for Resident #10 was					
		20/11 at 11:40 A.M. The					
		nitted to the facility on					
		nitial Minimum Data Set					
	(MDS) assessme	*					
	•	ed the resident was					
	_	ontinent of her bowels					
	and bladder.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747			(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 07/22/2 (ETED
	ROVIDER OR SUPPLIER		'	1300 ME	DDRESS, CITY, STATE, ZIP CODE ERCER AVE JR, IN46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	through 09/11 inc	h care plans, current dicated there was no plan sident's bowel and/or ence.					
	07/22/11 at 11:00 was no care plan	e Director of Nursing, on A.M., confirmed there located addressing ds for Resident #10.					
	3.1-35(a)						
F0280 SS=A	incompetent or oth incapacitated under	the right, unless adjudged nerwise found to be er the laws of the State, to hing care and treatment or and treatment.					
	of the comprehens by an interdisciplir attending physicia responsibility for the appropriate staff in by the resident's n practicable, the pathe resident's family representative; an	days after the completion wive assessment; prepared that includes the many team, that includes the many team, and other many team, and other many team, and other many team, and other many team, and the eds, and, to the extent many tricipation of the resident, many or the resident's legal deperiodically reviewed and of qualified persons after					
		ntion, record review, and	F02	280	What corrective action(s)	will	08/21/2011

li i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155747	B. WIN			07/22/2	011
NAME OF	PROVIDER OR SUPPLIEI	}		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	· ·	acility failed to ensure the			be accomplished for those residents found to have beer	,	
	health care plans	s for 1 of 24 residents			affected by the deficient	ı	
	reviewed for car	e plans in a sample of 24			practice?Program for resider	nt	
	were updated to	reflect the resident's			#25 was discontinued on 7/2		
	current needs. (Resident #25)			The care plan was updated t		
					reflect the change. Resident		
	Finding includes	3:			#25's flow sheet was taken of the CNA charting book as we		
					her name removed from daily		
	 1 During the ii	nitial tour of the facility,			walking list at the nurses'	,	
	conducted on 07/18/11 between 10:30				station.2. How other residen	its	
					having the potential to be aff		
	A.M 11:30 A.M., the Director of				by the same deficient practic		
	Nursing indicated Resident #25 was confused, ambulated independently,				be identified and what correct action(s) will be taken?In an		
		• •			to identify any other applicab		
	_	ghout the day, and was			residents, the Restorative Nu		
		. She indicated the			reviewed all ambulation prog	rams	
		e to complete activities of			for appropriateness of need.		
	1 .	cues and minimal			What measures will be put in		
		ng the tour of the facility,			place or what systemic chan will be made to ensure that the	-	
	Resident #25 wa	s observed ambulating in			deficient practice does not		
	the hallway and	was noted to follow or be			recur?The Restorative Nurse	e will	
	invited to follow	various staff members			provide an in-service for all		
	who were worki	ng on the unit. The			nursing staff on the		
	resident was not	ed to follow them for a			appropriateness of ambulation programs, including goals are		
	few minutes and	then wander off and			continuation on August 18,		
	approach a diffe	rent staff member.			2011. 4. How the corrective		
	^^				action(s) will be monitored to		
	The clinical reco	ord for Resident #25 was			ensure the deficient practice		
		19/11 at 1:00 P.M. The			not recur, what quality assurated programs will be put into place		
		nitted to the facility on			The Restorative Nurse will re		
		agnoses, including but			the ambulation list weekly tin		
		Izheimer's dementia and			weeks then monthly times 6		
	depressive disor				months with results to QA for	r	
	depressive disor	UCI.			appropriateness of program,		
	The same of	Minimum Data Cat			quarterly for the need for cha of goals and appropriateness		
	I ne most recent	Minimum Data Set			or goals and appropriatelless	, 01	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/22/2	LETED	
	PROVIDER OR SUPPLIER		P : 1121	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	(MDS) assessme completed on 05 resident was indestransferred indep moderate staff as personal hygiene. Review on 07/19 health care plans through 08/11, in restorative ambu goal for the reside room to the glass different nursing room daily. Interview with the 07/21/11 at 9:00 restorative ambu discontinued as obeing "inappropring to the property of the complete the c	int for Resident #25, /31/11, indicated the ependently ambulatory, bendently, and required esistance for dressing, e, and toileting needs. //11 at 1:00 P.M., of the for Resident #25, current edicated a plan for a lation program with the lent to ambulate from her est doors at the end of a unit and back to her in Administrator, on A.M., indicated the lation care plan had been of 07/21/11 due to it riate." She indicated the led by herself without		TAG	program. Restorative nurse service staff on appropriate of ambulation program, goa and continuation on August 2011.	ness Is,	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILDING 00 CC			(X3) DATE S COMPL 07/22/2	ETED	
	PROVIDER OR SUPPLIER REST NURSING CE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
F0282 SS=D	facility must be proin accordance with plan of care. Based on observating interviews, the far physician's order followed for 3 of for services to be 24 related to rester protectors and admedications. (Ref. 107) Finding includes: 1. a. During the inconducted on 07/A.M 11:30 A.M. Nursing indicated incontinent at timplan, required more for activities of discontinent at timplan, required more for activities of discontinuous. The clinical reconsequence of the conducted on 07/2 physician's order indicated the residuicated the residuicated from the conducted of the conducted on 07/2 physician's order indicated the residuicated from the conducted on 07/2 physician's order indicated the residuicated from the conducted on 07/2 physician's order indicated the residuicated from the conducted on 07/2 physician's order indicated the residuicated from the conducted on 07/2 physician's order indicated from the conducted on 07/2 physician's o	esidents #27, 69, and mitial tour of the facility, 18/11 between 10:30 M., the Director of d Resident #27 was nes but had a toileting oderate staff assistance aily living, propelled a lif and ambulated with erself, and required nectar and for Resident #27 was 10/11 at 9:30 A.M. A 1, dated 03/18/11,	F0	282	1. What corrective action(s) we accomplished for those residents found to have been affected by the deficient practice? Resident #27, Phys was notified that chin tuck on was not being followed. Phys ordered speech eval, which we completed on 7/22/11. At that time the speech therapist determined that chin tuck was inappropriate and order was dc'd. Resident #27 refuses to wear heel protectors at this time the physician was notified on 8/8/11 with orders received to heel protectors. Resident #27 toileting program was re-evaluated and an appropriate plan was put into place. The plan has been updated and to CNA sheet was updated to retoileting program. Resident #27 restorative ambulation program was re-evaluated and resident was placed on an appropriate program, with care plan and sheet updated. Resident #69 physician was notified of mis medication, medications were obtained and no adverse effect were noted. Resident #107, Physician was notified of medication error and no adverse effects were noted. 2. Hother residents having the potential to be affected by the	ician der sician was at s ome. n odc date care he eflect 27 am nt e CNA , the sed e ects erse ow	08/21/2011

´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155747	B. WIN	IG		07/22/2	011
NAME OF I	DROVIDED OD SLIDDI IED		'	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1300 ME	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECATU	JR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
	and supervision to ensure the resident				same deficient practice will b	е	
	tucked her chin w	vith each swallow.			identified and what corrective		
					action(s) will be taken?All ch		
	 Resident #27 wa	s observed on 07/19/11 at			of those residents eating in the lounge will be reviewed to er		
		again on 07/21/11 at			that staff is following appropr		
		_			physicians orders. Care plar		
		ed in her wheelchair in			and CNA sheets will be upda		
		ng room. The resident's			as needed. Residents with		
	1 -	t up for her and she was			orders for heel protectors wil		
		self. The resident did not			reviewed for compliance and appropriateness. Residents		
		cues to tuck her chin			toileting plans will be evaluat		
	each time she sw	allowed. The resident			and current toileting program		
	did not tuck her chin when she				be updated specific to individ		
	swallowed. The	resident coughed once			need. Care plans and CNA		
	after taking seven	ral consecutive sips of her			will be updated to reflect new		
	thickened juice.	Staff did cue her to eat			toileting programs.All residents currently on ambulation programs will be re-evaluated to determine appropriate individualized		
	more food, but n	o staff at either meal was					
	noted to cue her	to tuck her chin with each					
	swallow.				ambulation program. CNA sh	neets	
					will be updated with specific		
	h In addition t	here was a physician's			ambulation program. Care p		
		0/11, for the resident to			will be updated accordingly. residents receiving Hospice		
	1 '	fors on both feet while in			will have a list of Hospice	ouro	
	1 *	ors on both feet wille in			provided medications placed	in a	
	bed.			l	plastic sheath on the chart.		
	Davidant 1107	1			MAR will be reviewed for any	/	
		s observed on 07/19/11 at			missed medications. 3. What measures will be pu	ıt into	
	· ·	t 11:15 A.M., lying in her			place or what systemic chan		
		The resident's heels			will be made to ensure that the		
		to be lying on her bed			deficient practice does not		
	with no heel prot	ectors on either heel.			recur?All new speech therap	у	
					evaluations with recommendations will be		
	Resident #27 was	s observed again on		l	forwarded to the Restorative		
	07/21/11 at 9:15	A.M., lying in her bed.			Nurse who will obtain physic		
	Both feet were no	oted to have footie hose			order, notify POA, educate s	taff of	
	on them and no h	neel protectors. Her heels			residents specific needs, upo	date	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED			
		155747	B. WIN			07/22/2	011		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ERCER AVE				
WOODC	REST NURSING C	ENTER	DECATUR, IN46733						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		 	TAG	DEFICIENCY)	DATE			
	were noted to be lying directly on top of				CNA sheets and care plan.				
	the resident's bed	dspread.			will be in serviced that treatment is on the TAR, requiring nursing				
						staff to observe and document			
	c. The current h	nealth care plans for			proper placement of heel				
		ated as current through			protectors. CNA sheets and	care			
	•	ed restorative care plan			plans will be updated				
		nd toileting needs.			appropriately. CNAs will be				
	Tor uniounation a	na toneting needs.			serviced to refer to CNA she	et for			
	On 07/10/11 of 1	1:40 A.M., Resident #27			resident's toileting program. Restorative Nurse will be				
		· · · · · · · · · · · · · · · · · · ·			responsible for evaluating an	ıd			
		her wheelchair and pushed			updating toileting programs,				
	to the assisted dining room by staff. The				sheets and care plans. CNAs				
		noted to be taken to the			be in serviced to refer to CN/	4			
	bathroom before	the meal.			sheet for specific directions				
					regarding residents restorative programs. Restorative RN w				
	On 07/21/11 at 9	2:15 A.M., Resident #27			responsible for evaluating ar				
	was noted to be	in bed. At 9:35 A.M.,		updating ambulation plans, CNA					
	CNA #6 was not	ed to be pushing Resident		sheets and care plans as well as					
	#27 out of her ro	oom. Interview with CNA			informing staff of any change				
	#6 indicated the	resident's bed alarm was			Policy for obtaining temporar				
	sounding and the	e resident was toileted			supply of medications from A Pharmacy will be revised and				
	I -	s usually what she needed			serviced on August 18, 2011				
		o get out of bed. CNA #6			in-service will be held on Aug				
		ent #27 was toileted when			18, 2011, to alert nurses to c	heck			
		, indicated she needed to			EDK, call pharmacy or AMH				
					nursing supervisor for tempo	-			
	-	om and was not on any			supply when medication is of stock.	ut OI			
	1 ^	e. CNA #6 indicated			4. How the corrective action(s)			
		s usually continent of her			will be monitored to ensure the				
		der during the day time			deficient practice will not rec				
		indicated Resident #27			what quality assurance progr	ams			
	_	t from her bed to the			will be put into place? ADON/DON will monitor 5				
	wheelchair but d	lid not ambulate.			residents with specific feeding	a			
					plans weekly times 6 months				
	CNA #7 was que	eried regarding Resident			ensure physicians orders are				
	1	at 3:00 P.M., and			followed with results to QA.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155747		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPI 07/22/2	LETED	
		100747	B. WIN		DDDDGG GYMY GWARD GYD GODD	0172272	.011
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ERCER AVE		
WOODC	REST NURSING C	CENTER		1	UR, IN46733		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		I	(X5)
PREFIX	,	FICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sident was ambulated in			will be audited by night shi		
	her room from h	ner bed to the bathroom			charge nurse weekly times months to ensure heel pro		
		oulated in the hallway.			are appropriate and order		
	She indicated th	e resident was toileted			carried out with results to	-	
	upon her reques	t and was not on any			ADON/DON will monitor 5		
	specific toileting	g schedule.			residents with toileting pro	-	
					to ensure program is being followed weekly times 6 m		
	Review of the Ju	uly Restorative Flow sheet			with results to QA committ		
	record indicated the resident was to ambulate with a rolling walker and a gait belt behind her wheelchair from her room				ADON/DON on days work		
					monitor 5 residents with		
					ambulation programs weel times 6 months to ensure	kly	
	to the assisted dining room for meals and from her room to the fire doors two times				appropriateness and progr	am is	
					being carried out with resu		
		ed. The resident's record			QA committee. Medication		
		d as having completed the			report will be completed w		
		gram for day and evening			hours and turned into the I any medication that is con		
	1 .	1 - 20; even though the			unavailable. Results will g		
	nursing staff we	_			ongoing. MAR will be aud		
	ambulating the				weekly by night shift charg		
		esident.			with any missing medication		
					reported to DON ongoing vesults to QA.	VILII	
	2. Resident #69	's record was reviewed					
		:45 p.m. Resident #69's					
		ded but were not limited to					
	1	stive failure, and					
	pulmonary eden	-					
	Pannonary eden						
	A current physic	cian's order indicated					
	1	medication for pain) had					
	been ordered 5/1						
		25 milligrams every 8					
		patch and Neurontin (a					
	-	pain) 100 milligrams three					
	1	ad been ordered 7/12/2011.					
	Lumes per day na	iu been ordered //12/2011.					1

000556

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING OO COMPLETE A. BUILDING	ED
	4
155747 B. WING 07/22/2011	1
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1300 MERCER AVE	
WOODCREST NURSING CENTER DECATUR, IN46733	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
And in a Cally Madient	
A review of the Medication	
Administration Record (MAR), dated	
7/2011, indicated initials of the nurse	
administering Scopolamine were circled	
on 7/16 at 8 p.m.; and 7/17/2011 at 6 a.m.,	
noon, and 8 p.m. On the back of the	
MAR, under the date 7/16/2011, the	
record indicated Scopolamine was not	
given as there was no supply on hand.	
A review of the Medication	
Administration Record (MAR), dated	
7/2011, revealed initials of the nurse	
administering Neurontin were circled on	
7/14- 8 p.m. dose, 7/15- noon and 8 p.m.	
dose; 7/16- noon and 8 p.m. doses; 7/17-	
8 am, noon and 8 p.m. doses; and 7/18-8	
a.m. and noon doses. On the back of the	
MAR, under the date 7/14 and 7/15/2011,	
the record indicated medications were not	
given as there was no supply on hand and	
the facility was awaiting family and	
hospice to supply the medication.	
Interview with the Director of Nursing, on	
07/19/11 at 5:45 P.M. indicated the	
medications were available in the EDK	
(emergency drug kit) or from the hospital	
pharmacy and should have been given.	
3. Resident #107's record was reviewed	
7/20/2011 at 2:45 p.m. Resident #107's	
diagnoses included but were not limited to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPI 07/22/2	LETED	
	PROVIDER OR SUPPLIEF		'	1300 ME	DDRESS, CITY, STATE, ZIP CODE ERCER AVE JR, IN46733	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	end stage heart of failure and depre	lisease, congestive heart ession.					
	5/31/2011, indicate BID had been or A physician's order.	ian's order, dated ated Humulin N 30 units dered 5/1/2011. der, dated 6/20/2011, Novolin N in place of					
	6/2011, revealed administering in a.m., were circle MAR, under the at 8:00 a.m., the	Record (MAR), dated initials of the nurse sulin on 6/20/2011 at 8:00 d. On the back of the date and time 6/20/2011 record indicated Novolin tot given as there was no					
	7/2011, revealed administering in a.m. were circled MAR, under the 8:00 a.m., the re-	Record (MAR), dated initials of nurse sulin on 7/8/2011 at 8:00 d. On the back of the date and time 7/8/2011 at cord indicated Novolin N given as there was no ock.					
	Administrator or	n 7/20/2011 at 10:00 a.m. armacy had been notified					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 07/22/2011			ETED		
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ERCER AVE JR, IN46733	0112212	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	The pharmacy stewas willing to su communicate with 6/20/2011, causin Additionally, on not ordered the indose. In an interview of the Administrator specific policy complysician orders,	umulin N on 6/17/2011. bocked Novolin N, and bstitute, but did not th the facility until ng a missed dose. 7/8/2011, the facility had nsulin causing a missed n 7/20/2011 at 2:30 p.m., r indicated there was no oncerning following but it was understood rders should be followed.					
F0309 SS=D	must provide the reto attain or mainta physical, mental, a in accordance with assessment and passed on record facility failed to incontinence was 1 of 13 residents	review and interview, the	F0.	309	1. What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? Resident #10 was placed on a bowel program for frequently incontinent of bow Care plan and CNA assignments were updated to reflective.	or el. ent	08/21/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID: 000556

If continuation sheet

Page 34 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED		
		155747	B. WIN			07/22/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				ERCER AVE			
WOODC	REST NURSING C	ENTED		I	UR, IN46733			
	LEST NORSING CI	ENTER		DECAI	UK, 1140733			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	Finding includes:				frequently incontinent of	.		
_				bowel. 2. How other residen	l l			
	During the initial	I tour of the facility,			having the potential to be aff			
	1	/18/11 between 10:30			by the same deficient practic be identified and what correct			
					action(s) will be taken?All	ilive		
		M., the Director of			residents frequently inconting	ent of		
		d Resident #10 was			bowel will be assessed to en			
	l * *	ed maximum staff			toileting program is addresse			
	assistance for Ac	tivities of Daily Living,			the care plan with an approp			
	and was incontin	ent of her bowels and			plan and the CNA assignmer	nt		
	was toileted by s	taff.			sheet is updated to reflect			
	ĺ				program.3. What measures	will		
	The clinical record for Resident #10 was				be put into placed or what	4.4.		
		20/11 at 11:40 A.M. The			systemic changes will be ma ensure that the deficient prac			
					does not recur?Restorative			
		nitted to the facility on			will implement a bowel/bladd	l l		
	06/17/11. The in	iitial Minimum Data Set			care plan based on the resid			
	(MDS) assessme	nt, completed on			needs following the 7 day dia			
	06/30/11, indicat	ed the resident was			as changes arise, quarterly,	and		
	occasionally inco	ontinent of her bowels.			as needed. A new form was	l l		
		ontinent of bowel was			implemented. Forms will be	in		
		incontinent episode in a			serviced on August 18 by			
		meontment episode in a			the Restorative Nurse along	with		
	week.				reeducation on bowel incontinence programs.4. He	0)//		
					the corrective action(s) will b			
	An Evaluation of	f Bowel assessment,			monitored to ensure the defice	l l		
	completed on 06	/28/11, indicated both			practice will not recur, what			
	incontinence of b	powel and continent of			quality assurance programs	will		
		eated on the form. The			be put into place?Weekly the			
	resident was note				Restorative Nurse will bring			
		l "absent" need to			bowel/bladder flow sheets to			
					plan meeting and the ADON			
	defecate documented. The resident was				check accuracy of flow sheet care plan and CNA sheet.	t with		
		aily elimination pattern			Results of findings to QA time	es 6		
	but no timeframe	e for the pattern was			months.			
	noted.							
	The health care r	plans, current through						
		,						

000556

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING B. WING (X3) DATE S COMPLIANT 07/22/20			ETED		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
F0311 SS=D	O9/11, indicated of address the resided address the resided Interview with the O7/22/11 at 11:00 was no additional any more specific regarding a bower management plant of the section. A resident is given and services to material abilities specified it section. Based on observation interview, the fact restorative service and toileting for for restorative section. Findings included 1. Resident #34's reviewed on 7/11 record indicated to the facility on Resident #34 had	the appropriate treatment aintain or improve his or her in paragraph (a)(1) of this ation, record review and cility failed to provide es related to ambulation 3 of 6 residents reviewed rices in a sample of 24. clinical record was //11 at 2:50 P.M. The the resident was admitted 2/7/11.	F0	TAG 311	1. What corrective action(s) be accomplished for those residents found to have beer affected by the deficient practical action and toilet were removed from care plan. #51-Ambulation list was charfor resident to ambulate from chair to bathroom and back. Care plan and CNA Assignm sheet updated to reflect goal change. #27-Staff re-educate ambulation and toileting programs. The resident is be ambulated and toileted account of the programs of the programs of the programs. The resident is be ambulated and toileted account of the programs of the programs. The resident having the programs of the programs. The resident is be ambulated and toileted account of the programs of the program of the programs of the programs of the program of th	will ntice? to of ent d on eing rding .2.	DATE 08/21/2011
	3/11, for a restora	ntive program: toileting			potential to be affected by th		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

If continuation sheet

Page 36 of 81

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155747 07/22/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 MERCER AVE WOODCREST NURSING CENTER DECATUR, IN46733 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE schedule which indicated the resident same deficient practice will be identified and what corrective requires nursing intervention to maintain action(s) will be taken?All bowel continence and promote residents on toileting and self-performance in toileting. The goal ambulation programs will be assessed by the restorative nurse was for the resident to maintain signs of for appropriateness, bowel continence daily with current toilet completeness, care plan schedule thru next review. The accuracy, and that the accurate approaches included, but were not limited program is on the CNA to: 1) Assist and offer bathroom with assignment sheet.3. What measures will be put into place or scheduled hours. Scheduled hours are what systemic changes will be located on restorative maintenance log in made to ensure that the deficient restorative book. Requires cues and practice does not encouragement for bowel program; 2) recur?Restorative programs will be placed on the CNA daily Resident requires limited (sic) of 1 staff assignment sheets. An member with toileting (transferring on/off ambulation ticket will be given to commode); 3) Prompt resident to stand residents at random on the and pivot with transfers. Cue to use bars ambulation program to be returned to the restorative nurse to help with transfers. after they have been ambulated. Toileting tickets will be placed Review of the July 2011 Restorative randomly for the CNA to return to Maintenance Log indicated the resident the Restorative Nurse after toileting has been completed. An was to be toileted upon rising, before in-service will be held on August lunch, before supper and second bed 18, 2011, where the Restorative check at night. The log indicated from Nurse will educate on toileting July 1, 2011 through July 19, 2011, the programs and ambulation programs. New forms have been resident had been incontinent of bowel on implemented.4. How the night shift every night with 8 of the nights corrective action(s) will be incontinent of bowel twice. The log monitored to ensure the deficient indicated on 1st shift the resident was practice will not recur, what quality assurance programs will incontinent of bowel once on 7/6/11, be put into place? Each resident twice on 77/7/11, 7/10/11, 7/12/11, on ambulation and/or toileting 7/13/11 and 7/14/11. The resident was programs will be monitored for incontinent of bowel three times on correct program and completion of program by the Restorative 7/8/11, 7/9/11 and 7/11/11. On second

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

If continuation sheet

Page 37 of 81

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155747	B. WIN			07/22/2011
NAME OF I	NAME OF PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
WOODC				1	ERCER AVE	
	REST NURSING CI				UR, IN46733	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			+	IAG	Nurse weekly times 4 and	DATE
		was incontinent of bowel			monthly thereafter times 6	
	· ·	7/2/11 and 7/19/11 and			months with results to QA.	
		owel twice on 7/10/11 and				
		forative maintenance log				
		f the resident was				
	_	ng, before lunch, before				
	supper and at sec	cond bed check at night.				
	An interview wit	th CNA's #6, 7, and 8 on				
		M., indicated on second				
	· ·	is asked before supper if				
		he bedpan. CNA's 6, 7,				
	and 8 indicated the	•				
		ence and they do not				
	_	let the resident before				
	· ·	lent's restorative health				
	_	ed the resident was to be				
		mode before supper on				
	second shift.					
	An interview wit	h RN #9, the restorative				
	nurse, on 7/19/11	at 2:05 P.M., indicated				
	CNA's are to try	to take the resident to the				
	toilet upon arisin	g, before lunch, supper				
	and at second be	d check at night.				
	2 a Resident #5	1's clinical record was				
		1/11 at 11:15 A.M. The				
		the resident had a				
		h care program for				
	_	e which had the problem				
	as the resident re	-				
	intervention to m	•				
	continence and p	romote self-performance				

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155747		ILDING	00	07/22/2	
		100747	B. WIN		DDDEGG CITY CTATE ZIR CODE	OTTEETE	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		goals were the resident					
	_	of urinary continence					
	1 -	t toilet schedule and will					
		ate daily with assistance.					
	1 ^ ^	he restorative toileting					
	1	d, but were not limited to:					
	l '	er resident bathroom with					
		Scheduled hours are					
		ative maintenance log in					
	restorative book.						
	Review of the res	sident's Restorative Flow					
	Sheet for Toiletin	ng for July 1, 2011					
	through July 20,	2011 indicated the					
	resident was to b	e assisted with toileting					
	on rising, before	and after breakfast, after					
	an activity, after	lunch, midafternoon,					
	before and after s	supper, at bedtime and at					
	1st and last bed o	check at night. The July					
	flow sheet indica	ted the resident was					
		adder once every night.					
	1 -	resident was incontinent					
		on 7/12/11 and 7/13/11					
		/11, 7/6/11, 7/7/11,					
		/11. On second shift the					
		ontinent of bladder once					
	· ·	, and $7/9/11$. The resident					
		of bladder twice on					
		11, 7/7/11, 7/10/11,					
		, 7/19/11 and 7/20/11. On					
		resident was incontinent					
		times on 7/11/11 through					
		dent was noted to have					
	no continent blac	lder episodes in July on					

000556

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 07/22/2	ETED	
		155747	B. WIN		DDDEGG CITY STATE ZID CODE	0112212	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 -	econd shift. On first shift					
		noted to be continent of					
		7/19/11 and 7/20/11. The					
		ed to be continent of					
		7/10 through 7/17 and					
	three times on 7	/1/11.					
	The most recent	restorative progress note					
		ated "goal is to maintain					
		ce by being toileted per					
	1	toileting schedule.					
	1	aly incontinent, but will					
		es when taken to the					
	bathroom."	75 W 11611 CHILLEN TO VIIC					
	An interview wi	th CNA #10 on 7/21/11 at					
		ated the resident is only					
		room for toileting when					
		nd did not toilet her					
	according to a so						
		th the RN #9, the					
	restorative nurse	e, on 7/21/11 at 3:00 P.M.,					
	indicated she did	l not know the resident					
	was not being to	ileted according to her					
	schedule.						
	b. Resident #51	's clinical record was					
	reviewed on 7/2	1/11 at 11:15 A.M. The					
	record indicated	the resident had a					
	restorative healt	h care program for					
	ambulation start	ed 12/10. The problem					
	was identified as	s resident is unable to					
	ambulate indepe	ndently in hallway. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155747	A. BUI	LDING	00	07/22/2	
		155747	B. WIN			0112212	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	ENTER		1	ERCER AVE UR, IN46733		
					O11, 111 1 0733		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	goal was for the	resident to ambulate from	i				
	l ~	aurses' station using a					
		ssist as tolerated, daily at					
		eekly. The approaches					
	1	e not limited to, resident					
		re assistance of 1 staff					
	_	late with use of rolling					
		room to nurse's station.					
	l mon oou	to mark to dimension.					
	Review of the Ju	ly 2011 Restorative Flow					
		1 through 7/11/11					
		dent performed the task					
		th Rollator, gait belt, 1-2					
		r behind resident from					
	· ·	he nurses' station twice					
		requiring 15 minutes per					
	1	n 7/5/11 and 7/6/11					
	1 ^	which required 12					
	minutes per sessi	_					
	An interview wit	h CNA #10 on 7/21/11 at					
	1:45 P.M., indica	ated the ambulation they					
		n the morning was to					
	walk the resident	to the bathroom.					
	An interview wit	h RN #9, the restorative					
	nurse, on 7/21/11	at 3:00 P.M., indicated					
	the resident's am	bulation goal is not					
	appropriate at thi	s time and they are in the					
	process of chang	ing it. RN #10 indicated					
	the resident has h	nad a decline and staff					
	shouldn't have be	een documenting on the					
	restorative flow s	sheet as the resident was					
	not performing th	ne task of ambulating to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
		l .	B. WIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ERCER AVE		
WOODC	WOODCREST NURSING CENTER			1	UR, IN46733		
							(7/5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	DATE
IAG	†		+	IAG			DAIL
	the nurse's statio	П.					
	1	nitial tour of the facility,					
		/18/11 between 10:30					
	A.M 11:30 A.I	M., the Director of					
	Nursing indicate	d Resident #27 was					
	incontinent at tir	nes but had a toileting					
	plan, required m	oderate staff assistance					
	1	laily living, propelled a					
		elf and ambulated with					
		erself, and required nectar					
	thick liquids.	orseri, una requirea meetar					
	diffek fiquids.						
	The clinical reco	ord for Resident #27 was					
		20/11 at 9:30 A.M. The					
		re plans for Resident #27,					
		through 09/20/11,					
	included restorat	•					
		toileting needs. The					
	toileting care pla	in indicated the resident					
	was to be toilete	d before and after meals,					
	midafternoon at	shift change, at bedtime					
	and at all bed ch	ecks at night. The					
	ambulation care	plan indicated the					
		e ambulated with the					
		nd assistance of 1 staff					
	_						
	from her room to the lounge for meals and from her room to the fire doors two times						
	per shift.	and the doors two times					
	per sinit.						
	On 07/19/11 at 1	1:40 A.M., Resident #27					
		er wheelchair and pushed					
		•					
		ning room by staff. The					
	resident was not	noted to be taken to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR COMPLETE		
AND PLAN	OF CORRECTION	155747	A. BUI	LDING	00	07/22/2011	
		155747	B. WIN			0112212011	'
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	ENTER		1	ERCER AVE UR, IN46733		
					OIX, IIX+0700		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE C	DATE
0		the meal. On 07/21/11 at	1				5.11.2
		lent #27 was noted to be					
	· · · · · · · · · · · · · · · · · · ·	A.M., CNA #6 was noted					
		sident #27 out of her					
		with CNA #6, at this					
		ne resident's bed alarm					
		d the resident was					
		that was usually what she					
		tried to get out of bed.					
		d Resident #27 was					
		e, the resident, indicated					
		to the bathroom and was					
		fic schedule. CNA #6					
		nt #27 was usually					
		bowels and bladder					
		me hours. CNA #6					
	-	nt #27 was able to pivot					
		he wheelchair but did not					
	ambulate.	ne wheelchan but did not					
	amourate.						
	CNA #7 was que	ried regarding Resident					
	1	at 3:00 P.M., and					
	· ·	dent was ambulated in					
		er bed to the bathroom					
		ulated in the hallway.					
		e resident was toileted					
		and was not on any					
	specific toileting						
	specific tolletting	bonounic.					
	Review of the In	ly 2011 Restorative Flow					
		the resident was to					
		rolling walker and a gait					
		heelchair from her room					
		ning room for meals and					
	to the assisted un	ining room for means and					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155747	A. BUII		00	07/22/2	
		1007 11	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0172272	
NAME OF F	PROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CE	ENTER			UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		the fire doors two times	+ -	IAG			DATE
		ed. The resident was					
		aving completed the					
		ram for day and evening					
		1 - 20 even though the					
	nursing staff wer	_					
	ambulating the re						
	amounting the iv	osident.					
	Interview with th	ne Restorative Nurse, RN					
		at 2:00 P.M., indicated					
		tants were responsible for					
	_	ileting plans and some of					
		rograms. She was					
	•	ulation program for					
		s not being followed.					
		Z					
	3.1-38(a)(2)(B)						
	3.1-38(a)(2)(C)						
F0314		prehensive assessment of					
SS=D		ility must ensure that a rs the facility without					
		es not develop pressure					
		ndividual's clinical condition					
		they were unavoidable; and					
		pressure sores receives ent and services to promote					
	•	fection and prevent new					l
	sores from develo	-					
		ation, interview and	F0	314	 What corrective action(s) be accomplished for those 	Will	08/21/2011
	record review, th	e facility failed to ensure			residents found to have been	ı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155747 07/22/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 MERCER AVE WOODCREST NURSING CENTER DECATUR, IN46733 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE affected by the deficient practice? skin was thoroughly assessed under a #69-No corrective action needed. splint, puff boots were properly applied resident dismissed to and interventions were in place to prevent home.#113-puff boots were taken pressure areas for 3 of 4 residents from inventory as they were from another facility. WC facility's heel reviewed with pressure areas in a sample protectors were applied to of 24. (Resident #69, Resident #113, heels.#24-Braden scale was Resident #24) updated to reflect current status, white socks were removed and Findings include: puff boots were applied while in wheelchair-Resident is deceased.2. How other residents 1. Resident #69's record was reviewed having the potential to be affected 7/19/2011 at 3:45 p.m. Resident #69's by the same deficient practice will diagnoses included but were not limited to be identified and what corrective action(s) will be taken? All diabetes, stroke, and heart failure. residents with a brace, splint, or immobilizer were identified, a A review of Nurse's notes, dated 6/5/2011 Braden completed, skin at 2200 (11:00 p.m.), indicated the nurse assessed, and chart checked for physician order. All residents with checked Resident #69's right lower pressure ulcers on heels were extremity finding no skin tears, but assessed for intervention while in observing a 0.6 centimeter by 0.5 wheelchair on care plan, Braden centimeter open area where the brace was audited to reflect current risk for skin condition. Residents with applied to right lower extremity had been edema were assessed for correct fastened while Resident #69 was up preventative stockings and an during the day. The area was protected, audit was performed to ensure all the physician and family notified, and puff booties in the facility belonged to Woodcrest. 3. treatment initiated. What measures will be put into place or what systemic changes The Wound/ Skin Care Management will be make to ensure that the Documentation record indicated the area deficient practice does not recur?Braden will be completed on 6/5/2011 was a stage II pressure area upon admission, with skin issue, 0.6 centimeters by 0.5 centimeters and and quarterly by assessment less than 0.1 centimeters in depth with nurse. Only facility's heel 25% pink granulation tissue and redness protectors will be utilized and proper stocking will be used when surrounding the area. On 6/10/2011, the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ERCER AVE		
WOODC	REST NURSING C	ENTED			UR, IN46733		
	INLOT NONOING C	LIVILIX			OIX, IN40733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	area remained a	stage II pressure area			residents have edema. Care		
	measuring 0.3 ce	entimeters by 0.2			will indicate proper interventi for edema. Revised policy w		
	centimeters and	less than 0.1 centimeters			reviewed at in-service on Au		
	in depth. The are	ea had 80% pink			18, 2011 to ensure skin	gust	
	-	e and was reddened			assessments are completed	prior	
	_	s. The area was noted as			to removing and applying spl		
	healed on 6/14/2				braces, or immobilizers. Staf		
		.011.			in serviced on how to apply h		
	- · · · · // co · ·				protectors and how to identify		
		d been admitted to the			facility's heel protectors. Sta was in serviced on signs of	ιπ	
	•	2011. On the Nursing			edema and appropriate		
	Admission/ Sign	ificant Change			interventions. 4. How the		
	Assessment note	es, dated 5/31/2011, the			corrective action(s) will be		
	area marked skir	condition indicated			monitored to ensure the defic	cient	
	Resident #69 had	d no wounds present.			practice will not recur, what		
		ation of psoriasis on both			quality assurance programs	will	
		ssment Notes also			be put into place?The MR		
					coordinator will review completeness of chart and		
	-	ic splint/ brace was being			accuracy of assessment with	in	
		ght foot and the splint			24 hours of admissions on da		
	was to be placed	within the right shoe.			worked. The DON will monit	-	
					nurse notes for documentation	on of	
	The Medication	Administration Record,			skin assessment prior to app	lying	
	dated 6/2011, inc	dicated the brace had been			and removing splint, brace,		
	applied each mo	rning and taken off each			and/or immobilizer on days		
	* *	vere no notes on the			worked and DON will check to ensure order is on the chart.		
		g skin had been checked			will be ongoing with results to		
	under the splint.	5 Skiii lidd beeli elleeked			times 6 months. The admitti		
	diaci die spilit.				nurse will replace heel bootie	-	
	A review of Nurse's notes, dated 5/31/2011 through the time the pressure area had been identified on 6/5/2011 did not indicate skin checks or documentation of skin condition under or around the				with the faiclities heel protect		
					with each admission ongoing		
					results to QA. Night shift cha	arge	
					nurse will audit and new	,,	
					admission orders for accurace ongoing times 6 months with		
					results to QA.		
	splint had been o	completed.					
		1					

Facility ID:

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		NSTRUCTION 00	(X3) DATE : COMPL		
AND TEAN	or conduction	155747		LDING		07/22/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			1300 MI	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	JR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		cian's orders, dated		1710			Ditte
	• • •	ot indicate a splint was to					
	be worn.	1					
		nad not been completed					
	indicating risk fo	r pressure until 6/6/2011.					
	Δ care plan titled	Restorative Splint/					
		1/2011, indicated to					
	·	before applying the					
	1 ^	nitor skin integrity before					
	application and a	fter removal.					
		ler written 6/6/2011					
	1	nt was to be applied in					
	the morning and	be taken off at night.					
	 Physical Therany	Aide #3 indicated					
	*	ew 7/20/2011 at 2:20					
	"	naged most splints and					
	should be checki	ng skin under and around					
	splints when app	lying and removing the					
	splint						
	On 7/20/2011	0.05 m m 4h a Dimeston a C					
		2:25 p.m., the Director of d in an interview staff					
	_	eked the skin under and					
		on application and					
	removal.	rr ······					
	A current wound	policy provided by the					
		7/21/2011 at 3:10 p.m.,					
	· ·	I not indicate prevention					
	measures for avo	iding pressure areas					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1300 M	ERCER AVE		
WOODC	REST NURSING CE	ENTER		1	UR, IN46733	-	
(X4) ID	SUMMARY S		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
	under splints and	braces.					
		s record was reviewed					
	7/18/2011 at 11:	00 a.m. Resident #113's					
	diagnoses include	ed but were not limited					
	to, dementia with	n behavioral disturbances,					
	depression and h	igh blood pressure.					
		_					
	A physician's ord	ler, dated 7/11/2011,					
	1 ^ *	ots had been ordered to					
	_	sident #113's feet.					
	ac applied to rece	radii († 113 5 100).					
	Documentation of	on the Wound/ Skin Care					
	_	cumentation Sheet					
		a on the left heel had					
	l	red on 7/11/2011 and was					
		rea with skin intact,					
	approximately 4	-					
	centimeters and i	red.					
	~	vation on 7/18/2011 at					
	12:30 a.m., it wa	s noted the puff boots					
	had gel inserts. T	he dark blue insert areas					
	were to the back						
	During an observ	vation on 7/19/2011 at					
	1						
	9:15 a.m., it was noted the puff boots were on the feet, but with the gel insert to						
	the back of the fo	~					
	inc back of the R	λοι.					
	During an observ	vation of the Resident					
	_	t was noted the pressure					
		to the inside of the left					
	neer approximate	ely the size of a fifty cent					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		NSTRUCTION 00	(X3) DATE S COMPL		
1111012111	or condition	155747	A. BUI B. WIN	LDING		07/22/20	
NAME OF I	PROVIDER OR SUPPLIER		D. WII		ADDRESS, CITY, STATE, ZIP CODE		
					ERCER AVE		
	REST NURSING C			<u> </u>	UR, IN46733		770
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	l ^	ntact and dark brown					
		ector of Nursing and					
		or of Nursing reapplied					
	_	th the gel inserts to the When queried about the					
		on of the boot, both					
	1	inserts were to be on the					
		ot and immediately					
	changed the posi						
		er's instructions for the					
	1 -	led by the Administrator					
		a.m., indicated the gel					
	beneath the resid	ot was to be placed					
	beneath the resid	ent's neer.					
	1	itial tour of the facility,					
		/18/11 between 10:30					
		M., the Director of					
		d Resident #24 was ed maximum staff					
	l ' 1	ctivities of daily living,					
		er wheelchair by staff, and					
	1 ^	ers on her left heel and					
	1 ^	she had acquired in the					
	facility. The resi	ident was noted to be					
		eelchair in her room, she					
	1	ia a nasal cannula, and					
	1	er feet which were both					
	resting on the wh	neelchair foot pedals.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUI	LDING	00	COMPLE	
		155/4/	B. WIN	G		07/22/20)11
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE	-	
				1	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	UR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		s observed on 07/20/11 at					
	· ·	1:15 A.M., seated in her					
		r room. The resident was					
	noted to be wear	ing slippers on both feet					
	and both feet we	_					
	wheelchair pedal	S.					
	On 07/19/11 at 1	:15 P.M., Resident #24's					
		ed while she was lying in					
	1 ~	ifty cent piece sized,					
		area on her left heel. The					
	1 -	h her shins and feet was					
		scaly, and edematous.					
		also noted to be wearing					
		-					
	l =	with extra edema noted					
	1	the socks. The resident's					
		ed to be red but no open					
	areas were noted						
	The clinical reco	rd for Resident #24 was					
	reviewed on 07/1	19/11 at 10:50 A.M. The					
	resident was adm	nitted to the facility on					
		agnoses, including but					
	not limited to dia						
		osteoarthritis, and					
		al vascular accident with					
	right sided hemig						
	1.5. oraca nomi	- WI - WID.					
	Review of the me	ost recent Minimum Data					
	Set (MDS) assess	sment for Resident #24,					
	completed on 05	/27/11, indicated the					
	resident required	total staff assistance for					
	1 ^	nsferring needs, extensive					
	· ·	or dressing and hygiene					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155747	A. BUII		00	07/22/2011
		100747	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0172272011
NAME OF F	PROVIDER OR SUPPLIER			1	ERCER AVE	
WOODC	REST NURSING CE	ENTER		1	UR, IN46733	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ent was also noted to be				
	totally incontinent of her bladder. The resident was not noted to have a pressure ulcer. Review of a Braden Scale pressure ulcer					
		completed on 06/21/11,				
	indicated althoug	th the resident was				
	chairfast, had dia	gnoses of diabetes and				
		ar disease, was totally				
		r bladder and was totally				
	*	ff for mobility needs, the				
	resident was not	-				
	developing a pres	ssure ulcer.				
	Review of health	care plan, initiated on				
		dated as current through				
	08/11 indicated the	he resident's goal was to				
	have no skin brea	akdown. The plan was				
	*	0/11 due to a cellulitis				
ı		21/11 due to a pressure				
		and on 06/28/11 due to a				
	blister on the left					
		pressure ulcer prevention				
		of puff and/or waffle				
		esident was in bed, the lle, and extra protein				
		developed a pressure				
		re no interventions to				
		on the resident's heels				
		in her wheelchair,				
	_	ing socks and slippers.				
	3.1-40(a)(2)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/22/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F0315 SS=D	assessment, the firesident who enteresident who enteresident's clinical that catheterization resident who is incompropriate treatmurinary tract infect normal bladder fur Based on record facility failed to ensure a program restore bladder considents reviewed sample of 24. (Refindings include During the initial conducted on 07, A.M 11:30 A.M. Nursing indicate confused, require assistance for Act (ADLs), and was bowels and bladd staff.	review and interview, the thoroughly assess and a was developed to ontinence for 1 of 13 ed for incontinence in a desident #10)	F0315	1. What corrective action(s be accomplished for those residents found to have bee affected by the deficient practice?UA for resident #1 placed on chart. Results we faxed to physician for approorders. A seven diary elimit pattern was implemented for resident #10. Care plan up to reflect history of UTI and appropriate toileting program. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken? All residents with an order for a will have results placed on one by evening supervisor who also ensure physician notification. All residents with a residents with a residents with a change in condition to with a change in condition to the same action of the same and the same action of the same action.	on was ere opriate nation or dated m.2. the he be ve a UA chart will sed and		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		1			
WOODO	DECT NUIDOING O	ENTED		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAI	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 07/2	20/11 at 11:40 A.M. The			restorative nurse. Care plan		
	resident was adn	nitted to the facility on			reflect results with appropria		
	06/17/11. The initial Minimum Data Set				interventions.3. What meas		
					will be put into place or what		
	1 '	ent, completed on			systemic changes will be ma		
	1	ted the resident was			ensure that the deficient prac does not recur?Elimination	Juce	
	1	ontinent of her bladder			assessment will be part of		
	(less than seven	episodes of			admission packet and restor	_{ative}	
	incontinence).	There was no current			team will implement eliminat		
	health care plan	regarding toileting needs.			pattern upon		
		28			admission, quarterly, and wit	:h a	
	Review of a urin	anny aontinonas			significant change. Nursing		
	1	-			place the residents name on		
	1	pleted on 06/28/11,			clip board at nurse's station	when	
	indicated the res	ident had a history of			UA has been completed.		
	urinary incontine	ence as well as urinary			Evening supervisor will moni		
	tract infections.	Both diminished and			returned results; fax to physi and ensure documentation is		
	absent perception	n of voiding needs was			complete. This will be in ser		
	1	orm, and poor voiding			on August 18, 2011.4. How		
		•			corrective action(s) will be		
	1	g and urgency were			monitored to ensure the defi	cient	
	1	gh the resident had a			practice will not recur, what		
	1 -	ompleted on 06/22/11, the			quality assurance programs		
	results were not	noted on the assessment.			be put into place? All UA's v	vill be	
	The resident's ur	rinary incontinence was			monitored daily M-F by the		
	noted to be rever	rsible with implementing			evening supervisor for return		
		vel management program,			results and proper document ongoing times 6 months with		
	1	proving environmental			results to QA. MDS nurse w		
		~			monitor return of elimination	""	
	1 -	eating underlying			pattern upon admission,		
	1	nanaging pain. The			quarterly, and with a significa	ant	
	resident was ass	essed to have mixed and			chance before completing		
	urge incontinent	cy.			MDs weekly times 4 weeks v		
					working, monthly times 6 mo	nths	
	There were no m	neasures implemented to			with results to QA.		
	1	nprove the resident's					
	1	ncy. No patterning					
	completed to def	termine the most	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/22/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	appropriate toilet resident.	ting schedule for the					
	07/22/11 at 11:00 was no patterning	ne Director of Nursing, on O A.M., indicated there g record located and no information for Resident					
	3.1-41(a)(2)						
F0323 SS=E	environment rema hazards as is poss receives adequate devices to prevent Based on observa- record review, th safe storage of cl 2 of 2 units. This	nsure that the resident ins as free of accident sible; and each resident expervision and assistance accidents. ation, interview and refacility failed to ensure memicals for cleaning on thad the potential to esidents on the Forest	F0323	What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? The Rubbermaid disinfectant bucket has been moved inside the housekeep.	1		

		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155747	B. WIN	IG		07/22/2	011
NAME OF	DD OVIDED OD GLIDDI IEI		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			1300 M	ERCER AVE		
	REST NURSING C			DECAT	UR, IN46733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ood and 6 of 58 residents			cart. The cart is to be locked		
	on the Rosewood	d neighborhood.			all times. The housekeeping policy has been updated to	cart	
					include the buckets be place	d	
	Findings include:				inside. The carts to be place		
					front of the resident's door, a		
	During the envir	onmental tour on 7/			the cart should never be left		
	"	p.m., a Rubbermaid			unattended.2. How other		
	1				residents having the potentia		
		1/2 full of liquid was			be affected by the same defi		
	1 ^	he housekeeping cart			practice will be identified and what corrective action(s) will		
	close to Room 9				taken? In order to prevent the		
	unattended and v	was not within sight of the			deficient practice from affect		
	housekeeper. Th	e solution was identified			other residents the bucket w	-	
	by the Housekee	ping Supervisor as 20			stored in the locked cart.3. \	Vhat	
	Neutral Cleaner	and Disinfectant. There			measures will be put into pla		
	were no resident	s in the hallway at that			what systemic changes will be		
	time.	s in the nanway at that			make to ensure that the defice	cient	
	l time.				practice does not recur?The housekeeping supervisor is t	.0	
	D				monitor that all buckets be ke		
		onmental tour on			inside the cart. The	- P ·	
	1	4 p.m., a Rubbermaid			housekeeping staff was		
		1/2 full of liquid was			in-serviced on July 27, 2011.		
	noted on top of t	he housekeeping cart			policy for housekeeping cars		
	close to Room 9	01. The cart was			updated on July 25, 2011.4.		
	unattended and v	was not within sight of the			the corrective action(s) will b monitored to ensure the defice		
	housekeeper. Th	e solution was identified			practice will not recur, what	OIOI IL	
	1	eping Supervisor as 20			quality assurance programs	will	
	1 -	and Disinfectant. There			be put into place? The		
		s in the hallway at that			housekeeping supervisor wil	l do a	
	time.	s in the nanway at that			weekly audit for 4 weeks to		
	unie.				ensure buckets are inside ar		
		7/10/2011			cart is kept within sight and t monthly for 6 months with re		
	1 -	iew on 7/19/2011 at 1:20			to QA.	อนแอ	
	1 *	keeping Supervisor			sa		
	indicated the lid	of the container should					
	be kept locked a	nd the cart kept in full					
	1 -	ekeeper at all times.					

000556

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747				ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPLE 07/22/2 0	ETED
		155747	B. WIN			0//22/20	711
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CI	ENTER		1	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	During on intervi	iew on 7/20/2011 at					
	_	Assistant Director of					
	·	d there were 58 residents					
	_	st Glen neighborhood of					
	which 10 were co	C					
		obile; and 58 residents					
		Losewood neighborhood					
	of which 6 were	C					
	independently m						
	macpendentry in	oone.					
	A Material Safet	y Data Sheet dated					
		tled "20 Neutral Cleaner					
	and Disinfectant'						
		apervisor on 7/19/2011 at					
		ted the solution was					
	-	yes and skin and could					
		e mouth if swallowed.					
		dated 2/1/1990 and					
	revised 5/27/201						
		Cart Use" indicated the					
	· ·	pt with the housekeeper					
		he caddy with chemicals					
	was never to be u	unattended.					
	2.1.45(-)(1)						
	3.1-45(a)(1)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155747	B. WING			07/22/2	011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING C	ENTER			JR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329		ug regimen must be free					
SS=D		drugs. An unnecessary					
		hen used in excessive dose					
		e therapy); or for excessive					
		ut adequate monitoring; or					
		indications for its use; or in diverse consequences which					
		should be reduced or					
		ny combinations of the					
	reasons above.	ny combinations of the					
	Based on a compr	rehensive assessment of a					
	resident, the facilit	ry must ensure that					
	residents who hav	e not used antipsychotic					
		n these drugs unless					
		therapy is necessary to					
		ndition as diagnosed and					
		e clinical record; and					
		antipsychotic drugs receive ctions, and behavioral					
	_	ess clinically contraindicated,					
		ontinue these drugs.					
		review and interview, the	F0329	329	What corrective action(s)	will	08/21/2011
		-	10.		be accomplished for those		00/21/2011
		ensure 1 resident (#41) of			residents found to have beer	ı	
		wed for antipsychotic			affected by the deficient		
	medication use h	ad adequate indications			practice? Care plan for #41	was	
	for starting a nev	v antipsychotic			revised to show interventions	for	
	_	sample of 24. Also, the			agitation. Aggressive behavi		
	facility failed to	_			for #41 were documented to	show	
	_	•			need for Respirdol and an		
		gical measures before			aggressive care plan was	ified	
	_	as needed (PRN)			implemented. Physician clar diagnosis for Respirdol. #11		
		dication for 1 resident			nursing tries and documents		
	(#113) of 2 resid	ents reviewed for PRN			interventions prior to giving		
	psychotropic me	dications in a sample of			Lorazepam. Documentation	is	
	24.	•			provided on back of MAR.2.		
	-				other residents having the		
	Dindings include:				potential to be affected by the		
	Findings include	•			same deficient practice will be		
					identified and what corrective	÷	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		1			
WOODO	DEOT NUIDOING O	ENTED		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAI	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. Resident #41's	s clinical record was			action(s) will be taken? All		
	reviewed on 7/1	9/11 at 2:20 P.M. The			residents with prn anti-psych		
	record indicated the resident was admitted				medication were identified a	nd	
		1/28/09 and had			the MAR was checked for		
	_				appropriate intervention prior		
	_	ling, but not limited to,			administering the prn med. A residents with aggressive	-\II	
	dementia, histor	y of previous elopement,			behaviors were identified and	4	
	depression, agita	ation.			chart was audited for an	-	
					aggression care plan with		
	Review of the re	esident's physician's orders			interventions. All residents of	n an	
	1	/11 he was started on			anti-psychotic medication we	ere	
		illigrams (mg) for			audited for an appropriate		
	_				diagnosis.3. What measures		
	agitation and wa	indering.			be put into place or what sys		
					changes will be made to ens		
	Review of the re	sident's multidisciplinary			that the deficient practice do	es	
	notes from 6/2/1	1 through 7/08/11			not recur? All residents with aggressive behaviors will be		
	indicated on 6/1	1/11 at 5:00 P.M., the			discussed at 9a stand up		
		pelling self in wheelchair			meeting. SS will contact MD	S of	
	1	11 at 10:00 P.M., the			aggressive behaviors and the		
		· ·			behavior logs will be checked		
	_	pelling self in wheelchair			daily by SS when working. S		
	_	hall most of the shift and			will implement an aggressior	care	
	enjoys banging t	the wheelchair into closed			plan and nursing will notify		
	doors and entering	ng others room and the			physician of aggressive beha		
		irected several times.			The MAR will be checked we	•	
					by night shift charge nurse for		
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	th the Director of Numaire			appropriate documentation of interventions prior to giving r		
		th the Director of Nursing			along with checking order for		
	` ′	at 9:55 A.M., indicated			appropriate diagnosis. Staff		
		no ordered the Risperdal			in serviced on August 18, 20		
	generally gets hi	s information from the			How the corrective action(s)		
	nurse's notes and	d summaries on behaviors			be monitored to ensure the		
	from the Social	Service Director.			deficient practice will not rec		
					what quality assurance prog		
	An intomican	th the Social Service			will be put into place? SS wi	II	
					check all new anti-psychotic		
		/11 at 11:45 A.M.,			medication orders for approp		
	indicated the on	ly behavior tracking the			diagnosis weekly times 6 mo	nths	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155747	A. BUI	LDING	00	07/22/2011
		133747	B. WIN			0772272011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
WOODC	REST NURSING CE	NTFR		1	ERCER AVE UR, IN46733	
					G1X, 11X+0700	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		esident #41 in the past	- 		with results to QA. SS will ha	
	1 *	reports of wandering on			nursing call physician if diag	
	4/22/11, 4/23/11 and 4/24/11 with no				is missing or inappropriate.	
	· ·	f any interventions. The			charge nurse on night shift w check the MAR weekly ongo	
		irector indicated the			with results to QA times 6 mg	
		ealth care plan for			for appropriate interventions	
		ocial Service Director did			before administering prn med	d
		nad prepared a summary			along with an appropriate diagnosis.	
		pehaviors prior to the			diagnosis.	
	physician starting	•				
	Risperdal on 7/8/	-				
		's record was reviewed				
		00 a.m. Resident #113's				
		ed but were not limited to				
	_	chavioral disturbances,				
		nigh blood pressure.				
	acpression, and i	ngn oloou pressure.				
	A current physici	ian's order, dated 7/2011,				
		pam (a medication for				
		igrams was ordered on				
]	ven three times per day				
	as needed.	r r r r r r r r r r r r r r r r r r r				
	A review of the J	une 2011 Medication				
	Administration R					
		peen given without				
	_	f non-pharmacological				
		5/8, 11, 14, 16, 17, 20, 21,				
	23, 25, and 28/20					
	A review of the J	uly 2011 Medication				
	Administration R					
		peen given without				
		f non- pharmacological				
		<u> </u>				-

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155747	A. BUI	LDING	00	07/22/2	
		100747	B. WIN			0112212	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	NTER		1	ERCER AVE UR, IN46733		
					1		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
-	intervention on 7	· · · · · · · · · · · · · · · · · · ·		-			
		7072011.					
	A review of the N	Nurse's notes for the					
	above dates did not reveal any						
		gical interventions prior					
	1 1	tion of the Ativan.					
	Review of a heal	th care plan for anxiety,					
		3/10, indicated there were					
	no	,					
	non- pharmacolo	gical interventions.					
	•						
	In an interview o	n 7/19/2011 at 11:20					
	a.m., LPN #2 ind	licated interventions					
	completed prior t	to giving as needed					
	medications were	e documented on the back					
	of the Medication	n Administration Record					
	or in the Nurse's	Notes.					
	In an interview o	n 7/20/2011 at 12:15					
	p.m., the Social S	Services Director					
	indicated interve	ntions were supposed to					
	be attempted price	or to giving as needed					
	medications and	would be documented on					
	the Medication A	dministration Record or					
	the Behavior Tra	cking Record if the					
		been attempted prior to					
	administration.						
	A current policy,	dated 2/9/00 and					
	updated 6/2011,	and titled "Anti-psychotic					
	_	the physician should					
		eptable diagnosis for the					
		pic medications in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747			(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 07/22/2	ETED
		100747	B. WING	STREET AI	DDRESS, CITY, STATE, ZIP CODE	0112212	011
NAME OF I	PROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING C	ENTER		DECATL	JR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	not indicate non-	ll record. The policy did pharmacological re to be attempted prior					
F0385 SS=D	a recommendation admitted to a facility remain under the of each resident is and another physicare of residents with physician is unavareabased on record facility failed to of 7 residents revarea sample of 24 per treatment orders #24) Finding includes 1. During the initic conducted on 07, A.M 11:30 A.M.	review and interview, the ensure the physician for 1 riewed with infections in rovided care timely when were needed. (Resident tial tour of the facility, 18/11 between 10:30 M., the Director of d Resident #24 had a	F038	85	1. What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?No corrective action Resident #24, she is decease How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with BLE edema we assessed for redness and was and a need for physician notification. 3. What measure will be put into place or what systemic changes will be many	ofor ed.2. he e e e ere armth	08/21/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN		-	07/22/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 07/resident was adn 01/12/05 with di not limited to dia vascular disease. Review of a nurse 6:35 A.M., indic "noted BLE (b to be red et (and pain when asked pitting even with throughout the nupdated et states (medical doctor) A subsequent nu at 1500 (3:00 P.I. following: "resibright red in cold (Physician's nam (Physician's nam (Physician's nam May call tomorraname) has any number of the p.M., indicated the updated. There is given regarding.	ses note, dated 06/15/11 at ated the following: ilateral lower extremities) warm to touch denies. has BLE edema 3 + a legs being elevated ight. Oncoming nurse she will call the MD with update." Trse's note, dated 06/15/11 M.), indicated the legs cont (continues) to be or et warm to the touch. The legs of office notified. The legs out of office today. The legs cont (physician's			ensure that the deficient pradoes not recur?Policy, Notification Chane of Status revised and an all staff in-se was conducted on August 1: 2011. Staff was instructed to notify physician timely as starevised policy. 4. How the corrective action(s) will be monitored to ensure the defi practice will not recur, what quality assurance programs be put into place? M-F, the I will read nurses notes and 2 hour report sheet, checking BLE edema and ensure phy was notified when there is redness and warmth ensurir orders are in place. This will ongoing times 6 months with results to QA.	, was rvice 8, 0 ated in cient will DON 4 for sician	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND FLAN	OF CORRECTION	155747	A. BUII		00	07/22/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CE	ENTER		1	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		11:00 A.M., which	+	IAU			DATE
		dent's legs were still					
		warm to touch with 3+					
	l '	The on-call physician was					
	notified.	T Jan					
	A follow up nurs	ing progress note, dated					
	06/19/11 at 12:00	noon, indicated the on					
	call physician did	d not want to give any					
		Resident #24's legs but					
	l *	dent's regular physician					
	~	e following day or see the					
	resident in his of	fice.					
	A	as mate dated 06/20/11 at					
		ss note, dated 06/20/11 at), indicated an order,					
	l ` ` ′	ent #24's attending					
	1	een received for the					
	* *	x, to be given for 7 days					
	· ·	ent's cellulitis in her					
	lower extremities	s. This was five days					
	after the facility	had made the initial call					
	to inform the MI	O of the resident's					
	condition.						
	On 7/22/11 of 11	·00 A.M. in interview					
		:00 A.M., in interview of Nursing regarding the					
		g initial treatment for the					
	1	is indicated there was no					
		lay and lack of nursing					
	follow up with th	-					
	1						
	3.1-22(b)(1)						
	3.1-22(b)(2)						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
	PROVIDER OR SUPPLIER REST NURSING CI SUMMARY S		I	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F0406 SS=D	but not limited to, speech-language therapy, and ment services for mentar retardation, are recomprehensive plaprovide the require services accordance with § a provider of specservices. Based on observative interview, the fact recommendation the Annual Residuere followed for diagnosis of mentample of 24. (Resident #1) Finding includes 1. During the interview of the interview	pathology, occupational al health rehabilitative al illness and mental quired in the resident's an of care, the facility must ed services; or obtain the from an outside resource (in 483.75(h) of this part) from ialized rehabilitative action, record review and cility failed to ensure and services outlined in lent Review Assessment or 1 of 1 residents with a stal retardation in a	F0	406	1. What corrective action(s) be accomplished for those residents found to have beer affected by the deficient practice? Resident #1 will had ocumentation to show that is unable to participate in community integration prograshe will have POA represent established and documentatishows that she is unable to participate in self-care skills. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? When MMR residents are admitted Identify IDEC report and follow through with any special recommendations that they recommend. Only 1 other MMR resides in building with IDEC recommendations at the time.3. What measures will leput into place or what system changes will be made to ensuthat the deficient practice documents.	ave she ams. ation on 2. he e e e e e e e e e e e e e e e e e e	08/21/2011

000556

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155747	B. WIN			07/22/2	U 11
NAME OF	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
MOODO		ENTED			ERCER AVE		
	REST NURSING C			DECAI	UR, IN46733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION DATE
IAG	REGULATORY OR	LESC IDENTIFYING INFORMATION)		IAG	not recur? SS will provide m	ore	DATE
	D	1			documentation with what IDE		
		observed on 07/20/11 at			recommends and implement	care	
	1	on 07/21/11 at 9:30 A.M.,			plans. SS will follow up with		
		eelchair in the main			IDEC recommendations upo	n	
	1 .	ticipating in the activities			receiving and if not received within 90 days, SS	will	
	program offered	by the facility.			call and follow up.4. How the		
		1.0 D :1 . //4			corrective action(s) will be		
		ord for Resident #1 was			monitored to ensure the defic	cient	
		20/11 at 2:30 P.M. The			practice will not recur, what quality assurance programs	will	
	1	nitted to the facility on			be put into place? SS coord		
	1	agnoses, including but			will track all MMR residents a		
	1	rsonality disorder, seizure			any IDEC reports to be upda		
	disorder, and mi	ld mental retardation.			and ensure report is on the o		
					monthly times 6 months with results to QA.		
		Annual Resident Review			results to Q/ t.		
	Assessment loca	ted on the clinical record					
	was dated Octob	per 2004. During the daily					
	exit conference,	conducted on 07/21/11 at					
	3:30 P.M., the A	dministrator was asked to					
	provide any doc	umentation regarding any					
	needs related to	Resident #1's diagnosis of					
	mental retardation	on. On 07/22/11 at 9:15					
	A.M., the Social	Services Director					
	provided an Ann	ual Resident Review					
	Assessment (IDI	EC), completed on					
	12/02/10 for Res	sident #1.					
	Review of the II	DEC assessment					
	recommendation	s indicated they included					
	the following:						
	"4. (Resident's	name) benefits from					
	ongoing training	and support to encourage					
	her work on develop or minimally						
	1	f-care skills (sic),					

000556

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 07/22/2	LETED			
	OVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	in a community in cognitive and sociontinue to build, skills., 6. (Reside from continued uspecialized service integration8. (Resident from form representation, to the health declined. Interview with the 07/22/11 at 10:00 the facility only he developmental developme	ne) needs to be involved integration program for ial stimulation and to (maintain her social int's name) may benefit itilization of OBRA ses for community resident's name) may nal advocacy, health care advocate for her when es" The Administrator, on A.M., indicated because roused two residents with elays, they were not notes made quarterly by a different until 08/11, indicated regarding assisting the all representation, no of daily living skill rove self skills, there was the OBRA services for no activity care plan reted towards providing ration activities to the #1's social skills. The Social Services 2/11 at 9:15 A.M.,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/22/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	12/2010 IDEC as aware she needed recommendation She indicated she obtain legal repre- local OBRA cent	I just received the seessment and was not do address the seemade on the report. The had not attempted to desentation or contact the seer regarding possible defor Resident #1.						
F0425 SS=D	residents, or obtaidescribed in §483 facility may permit administer drugs it under the general nurse. A facility must proviservices (including accurate acquiring	and biologicals to its n them under an agreement .75(h) of this part. The unlicensed personnel to f State law permits, but only supervision of a licensed vide pharmaceutical g procedures that assure the l, receiving, dispensing, and I drugs and biologicals) to						
	of a licensed phari consultation on all pharmacy services Based on intervie facility failed to	ew and record review, the ensure medications were ninistration as the dered for 2 of 24	F0425	1. What corrective action(s) be accomplished for those residents found to have beel affected by the deficient practice? No action needed Residents #69 and #107.	1			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155747	B. WIN			07/22/2	011
			D. 1711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		1	UR, IN46733		
					G14, 111-101-00		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	, and the second	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	-	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	I	sample of 24. (Resident			Medications were already received and administered a	nt the	
	#69, Resident #1	107)			time of the survey.2. How o		
					residents having the potential		
	Findings include	2 :			be affected by the same def		
					practice will be identified and		
	1 Resident #69'	s record was reviewed			what corrective action(s) wil	l be	
		45 p.m. Resident #69's			taken?Medication error repo		
	1	-			must be completed within 24	1	
	~	led but were not limited to			hours and turned into	ion	
	1	stive failure, and			DON/ADON for any medicate that is considered unavailab		
	pulmonary eden	na.			nurses were in serviced on	ic. All	
					August 18, 2011 to follow ex	risting	
	A current physic	cian's order, dated			policy to reorder meds wher		
	7/15/2011, indic	eated Scopolamine (a			a 4 day supply remains and	follow	
	medication for r	pain) had been ordered			Order and Receipt of Drugs		
	1 ^	administered 0.25			Pharmacy Policy. All MAR		
		y 8 hours through a patch			reviewed for missed medica		
	1 -	a medication for pain) 100			by night shift charge nurse.3 What measures will be put it		
	1	• /			place or what systemic char		
	_ ~	e times per day had been			will be make to ensure that t		
	ordered 7/12/20	11.			deficient practice does not re		
					Staff will be in serviced on		
	A review of the	Medication			obtaining medications when	they	
	Administration	Record (MAR), dated			are not available in facility.		
	7/2011, revealed	l initials of the nurse			Revised policy reviewed at	11 /	
		copolamine were circled			in-service on August 18, 20' How the corrective action(s)		
	1	a.; and 7/17/2011 at 8 a.m.,			be monitored to ensure the	******	
	1	On the back of the			deficient practice will not rec	ur,	
	1	e date 7/16/2011, the			what quality assurance prog	rams	
	1				will be put into place? Night		
	1	Scopolamine was not			charge nurse will look at MA		
	given as there w	as no supply on hand.			weekly to ensure nurses are		
	1				following policy and report to		
	A review of the Medication Administration Record (MAR), dated			DON any discrepancies four ongoing with results to QA ti			
				6 months.			
	7/2011, revealed initials of the nurse						
	1	eurontin were circled on					
	I wanning IV	Caronian were entered on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/22/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	UR, IN46733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC1)		DATE
	1 ^	e; 7/15- noon and 8 p.m.					
	1 '	and 8 p.m. doses; 7/17-					
		8 p.m. doses; and 7/18-8 oses. On the back of the					
		date 7/14 and 7/15/2011,					
		ated medications were not					
		as no supply on hand and					
	1 ~	as no supply on hand and awaiting family and					
	1	y the medication.					
		y the medication.					
	In an interview of	on 7/21/2011, LPN #1					
		gh the family and hospice					
		d, the medication did not					
	arrive until 7/18						
	2. Resident #107	7's record was reviewed					
	7/20/2011 at 2:4	5 p.m. Resident #107's					
	diagnoses includ	led but were not limited to					
	end stage heart of	lisease, congestive heart					
	failure and depre	ession.					
		ian's order, dated					
	1	ated Humulin N 30 units					
	BID had been or	dered 5/1/2011.					
		1 1 / 1 / / 20 / 20 1 1					
	1 ^ -	der, dated 6/20/2011,					
		Novolin N in place of					
	Humulin N.						
	A review of the	Medication					
		Record (MAR), dated					
		initials of the nurse					
	· ·	sulin on 6/20/2011 at 8:00					
	1	d. On the back of the					
	a.m. were energy	a. On the back of the					

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155747	A. BUI B. WIN	ILDING NG		07/22/2	
	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN46733		
		TATEMENT OF DEFICIENCIES		ID	011, 114-07-00		(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	MAR, under the	date and time 6/20/2011					
	at 8:00 a.m., the	record indicated Novolin					
	N 30 units was n	ot given as there was no					
	Novolin N on ha	nd.					
	A review of the N	Medication					
		Record (MAR), dated					
		initials of the nurse					
	,	sulin on 7/8/2011 at 8:00					
	_	I. On the back of the					
		date and time 7/8/2011 at					
	8:00 a.m., the red	cord indicated Novolin N					
	30 units was not	given as there was no					
	Novolin N in sto	ck.					
	A document prov	vided by the					
	•	7/20/2011 at 10:00 a.m.,					
		rmacy had been notified					
	•	[umulin N on 6/17/2011.					
	The pharmacy st	ocked Novolin N, and					
	was willing to su	bstitute, but did not					
		th the facility until					
	· ·	ng a missed dose.					
	•	7/8/2011, the facility had					
		nsulin causing a missed					
	dose.						
	In an interview 7	7/19/2011 at 5:30 p.m.,					
		ed medications were					
		e hospital pharmacy					
	whenever they w						
	A 011mmorat1:-	doted 2/1/04 or 1 1-t-1					
		dated 2/1/94 and updated t Dose Dispensing					

000556

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		155747	B. WIN			07/22/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	NTER			ERCER AVE UR, IN46733		
					514, 11410700		aus)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	System indicated	the pharmacy's on call					
		e utilized to obtain					
		ore the next scheduled					
		en the medication is not					
	available in the e						
	3.1-25(a)						
	()						
F0505	The facility must b	romptly notify the attending	1				
F0505 SS=D	physician of the fir						
00-D		review and interview, the	F ₀	505	What corrective action(s)	will	08/21/2011
		notify the physician of an			be accomplished for those		00/21/2011
	_	nalysis (UA) result for 2			residents found to have bee		
		‡10 and #33) reviewed			affected by the deficient practice? Lab results were V	VNI	
	for lab results in	· · · · · · · · · · · · · · · · · · ·			faxed to physician with no fu		
		1			orders received for resident #		
	Findings include				Lab results were placed on c		
	S				for resident #33 and physicia notified of results.2. How oth		
	1. Resident #33's	s clinical record was			residents having the potentia		
		0/11 at 3:50 P.M. The			be affected by the same defi-		
		on 6/21/11 a physician's			practice will be identified and what corrective action(s) will		
		ed to start treatment with			taken?Every resident chart w		
	Levaquin for 7 da	ays for an urinary tract			reviewed for outstanding lab	-	
	•	nd to obtain a follow-up			orders on 8/5/11.3. What		
	, , ,	aquin course was			measures will be put into pla what systemic changes will b		
		1/1/11, a physician's order			make to ensure that he defic		
	•	a culture of urine if white			practice does not recur?A lat		
	blood count (WB	C) greater than 5.			tracking flow sheet was		
	`	· -			developed and has been		
					implemented to track labs		

000556

´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155747	B. WIN			07/22/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOODO		INTER		1	ERCER AVE		
	REST NURSING CE			DECAI	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re Co	OMPLETION DATE
IAG		A was obtained that		IAG	ordered, received and physic	rian	DATE
	l '	BC 25-50. A culture of			notification. In-service held f		
					nursing staff on obtaining lab)	
		completed. The UA lab was not available in the			results, placing on chart and		
		in the facility. On			physician notification.4. How corrective action(s) will be	tne	
		•			monitored to ensure the defice	cient	
		A.M., the lab faxed the facility			practice will not recur, what		
		A results to the physician			quality assurance programs	will	
		time on 7/20/11.			be put into place. Evening supervisor will monitor lab re	eulte	
	at an unspecified	time on 7/20/11.			for timely return, physician	Suits	
	An interview wit	h the Director of Nursing			notification, and chart placen		
		h the Director of Nursing			daily when working ongoing		
	l ` ′	at 9:45 A.M., indicated			results to QA times 6 months	S.	
		s should have been in the					
	_	etion and the physician					
		notified of the lab					
	results.						
	2 The eliminal re	ecord for Resident #10					
		07/20/11 at 11:40 A.M.					
		ler was received on					
		inalysis to be done with a					
		tivity test if there were					
		than 5 white blood cells					
	in the resident's u						
	in the resident's t	irmarysis test.					
	Review of the ur	inalysis test results,					
		/22/11, indicated there					
	1 ^	te blood cells in the					
		However, there were no					
		tivity results noted in the					
		l record. The urinalysis					
		received by the facility					
		A culture and sensitivity					
		ovided, on 07/22/11,					
	1 3350 1 35 and 11 and pr	- :					

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 07/22/2 (ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	PF	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION
TAG	dated as completed indicated there we contaminants." the facility was a specimen and no had been contact retest was not defined. Interview with the 07/22/11 at 11:00 resident's physical	There was no indication ware of the contaminated indication the physician ed timely to ensure a sired by the physician. The Director of Nursing, on D. A.M., indicated the fan had not been made and sensitivity had not		TAG			DATE
F0507 SS=D	record laboratory r	le in the resident's clinical reports that are dated and address of the testing					
	facility failed to of were available or residents reviewed	ew and record review, the ensure laboratory results in the chart for 3 of 24 ed for lab results on the of 24. (Resident #84,	F050	07	1. What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? #10-7/22/11, Phys was notified of results with no further orders received. #33, Physician was notified of resulth no further orders received.	ician o ults	08/21/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM11

Facility ID:

000556

If continuation sheet

Page 73 of 81

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDDIC	00	COMPL	ETED
		155747	A. BUII B. WIN			07/22/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	₹		1			
WOODO		ENTED		1	ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAI	UR, IN46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	e:			#84, Lab results were WNL,		
					faxed to physician with no fu		
	1 Resident #84's	s record was reviewed			orders received.2. How other		
		40 a.m. Resident # 84 's			residents having potential to		
					affected by he same deficien		
	1 -	led but were not limited to			practice will be identified and what corrective actions(s) wi		
	1	plood pressure, and			taken? Every residents' cha		
	osteoporosis.				was reviewed for outstanding		
					current lab orders on 8/15/11		
	A current physic	ian's order summary			evening supervisor.3. What		
	1	and CBC were to be			measures will be put into pla		
	drawn yearly.				what systemic changes will be		
	drawn yearry.				made to ensure that the defi		
					practice does not recur? A la	ıb	
	1	oratory results revealed			tracking flow sheet was		
	BMP and CBC r	results for $6/2/2010$, but			developed and has been implemented to track labs		
	no results were	on the current chart after			ordered, received, and physi	cian'	
	that time.				s orders received. Staff was		
					in-service on August 18, 201		
	In an interview of	on 7/21/2011 at 11:00			How the corrective action(s)	will	
		nt Director of Nursing			be monitored to ensure the		
		-			deficient practice will not rec		
		s had been drawn, but the			what quality assurance progr		
		on the chart. She further			will be put into place?Evenin supervisor will monitor lab re		
		was faxing the results so			for timely return, physician	อนแจ	
	they could be pla	aced on the chart.			notification, and chart placen	nent	
					daily when working ongoing		
	On 7/21//2011 a	t 1:45 p.m., the Assistant			results to QA times 6 months		
		ing provided the lab					
		MP and CBC obtained					
		esults were within normal					
		suns were within normal					
	limits.	10 0 11					
		ecord for Resident #10					
	was reviewed on 07/20/11 at 11:40 A.M. A physician's order was received on						
	06/21/11 for a un	rinalysis to be done with a					
	1	itivity test if there were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMP 07/22/2	LETED		
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER			B. WING OTT 22/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	(X5) COMPLETION		
TAG		than 5 white blood cells urinalysis test.	ů	TAG	DEFICIENCY)		DATE	
	completed on 06 were 10 - 15 whi resident's urine. culture and sensi resident's clinica results were not until 07/13/11. A test result was pr	inalysis test results, /22/11, indicated there te blood cells in the However, there were no tivity results noted in the record. The urinalysis received by the facility a culture and sensitivity ovided, on 07/22/11, ed on 06/23/11, which ras a "growth of						
	reviewed on 7/19 record indicated order was received Levaquin for 7 d infection (UTI) a UA once the Lev completed. On 7 was received for the white blood of than 5. On 6/30/11, a UA indicated the WE urine was not corresult of 6/30/11	clinical record was 0/11 at 3:50 P.M. The on 6/21/11 a physician's ed to start treatment with ays for an urinary tract and to obtain a follow-up aquin course was (1/11, a physician's order a culture of the urine if count (WBC) was greater A was obtained which BC 25-50. A culture of the mpleted. The UA lab was not available in the in the facility. On						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 155747			A. BUILD	DING	OO	(X3) DATE S COMPL 07/22/20	ETED		
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE					
					JR, IN46733				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	7/20/11 at 9:46 A.M., the lab faxed the UA results to the facility and the facility then faxed the UA results to the physician at an unspecified time on 7/20/11.								
	(DN) on 7/20/11	h the Director of Nursing at 9:45 A.M., indicated s should have been in the etion.							
	3.1-49(f)(4)								
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to iden the resident's asse and services provi	naintain clinical records on eccordance with accepted ards and practices that are ely documented; readily estematically organized. must contain sufficient tiffy the resident; a record of essments; the plan of care ded; the results of any ening conducted by the es notes.							
	Based on record	review and interview, the ensure physician's orders	F05	14	What corrective action(s) be accomplished for those residents found to have been		08/21/2011		

A. BUILDING B. WING O7/22/2 STREET ADDRESS, CITY, STATE, ZIP CODE	011
NAME OF PROVIDER OR SUPPLIER	
WOODCREST NURSING CENTER 1300 MERCER AVE DECATUR, IN46733	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continue of the provider's plan of correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
were correctly transcribed or clarified in the clinical record for 2 of 24 residents (Residents #34 and #1) in a sample of 24. Findings include: Findings include: 1. Resident #34's clinical record was reviewed on 7/18/11 at 2:50 P.M. The record indicated the resident was readmitted to the facility from an acute care setting on 5/10/11. On the physician's orders on readmission on 5/10/11 medication orders were received to discontinue Lantus (insulin) 20 units at bedtime (hs). On 5/24/11, the resident's monthly physician's orders indicated Lantus 20 units to be given at bedtime. On the monthly physician's orders from 6/28/11 indicated Lantus 20 units to be given at bedtime. On the facility on 5/10/11, the resident was to have Accuchecks (finger stick blood sugar monitoring) for blood sugars before each meal and at bedtime with insulin coverage before meals with no sliding scale insulin coverage at bedtime.	DAIE

AND PLAN OF CORRECTION 155747 15747	STATEMENT OF DEFICIENCIES (X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER WOODCREST NURSING CENTER ISTREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733 ID PROVIDER AT A OF CORRECTION COMPLETION DATE Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	A RUILDING 00		COMPLETED		
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER ISTRECT ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, INA6733 (X5) PREFIX TAG REQUILATORY OR LSC IDENTIFYING INFORMATION) Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a			155747				07/22/2011		
WOODCREST NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a				D. ((1)		ADDRESS CITY STATE ZIP CODE			
CA1 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENS PLAN OF CORRECTION (CAS) ID PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) TAG Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a	NAME OF PROVIDER OR SUPPLIER								
Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a	WOODC	REST NURSING C	ENTER						
Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a	(X4) ID			\neg	ID I		(X5)		
Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a						(EACH CORRECTIVE ACTION SHOULD BE			
Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a	TAG	1			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a				İ		night shift supervisor will che	ck		
readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		Administration I	Records (MARs) from						
indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a						· · · · · · · · · · · · · · · · · · ·			
medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a			•						
on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		1	_			results to QA.			
at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		1	on a sliding scale at						
(DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		bedtime.							
(DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		(DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites.							
the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a		reviewed on 07/2	20/11 at 2:30 P.M. A						
indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a									
antibiotic, Flagyl 500 mg, three times a									
			•						
		1 * '							
time frame given for how long the			•						
antibiotic was to be given. Review of the									
		medication administration record for May 2011 indicated the Flagyl was given for 7 days and then was discontinued. The physician was not notified of the need to clarify the antibiotic order to include the length of treatment desired.							
clarify the antibiotic order to include the									
length of treatment desired.									
Interview with the Director of Nursing, on		Interview with the	ne Director of Nursing, on						
		07/22/11 at 11:0	0 A.M., indicated there						

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155747	A. BUILDING		00	COMPLETED 07/22/2011		
100747		199747	B. WING			0112212	011	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
WOODC	REST NURSING CE	ENTER			RCER AVE IR, IN46733			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I ID I				(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PR	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		_	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Г	ſAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	was no clarification made and no							
	additional information available regarding							
	the lack of a stop date for the Flagyl for							
	Resident #1.							
	2.1.50(.)(2)							
	3.1-50(a)(2)							
F9999								
			F9999		What corrective action(s)	will	08/21/2011	
					be accomplished for those			
	STATE FINDING	STATE FINDINGS			residents found to have been affected by the deficient	1		
					practice? Physical for emplo	yee		
	3.1-14 PERSON	INEL			#12 has been signed by the			
				physician.2. How other residents having the potential to be affected				
		amination shall be		by the same deficient practice will identified and what corrective				
	-	employee of a facility						
	within one (1) m	•			action(s) will be taken? Infec			
		e examination shall			Preventionist #2 will check all Woodcrest employee files to ensure the physician signature is			
		llin skin test, using the						
	Mantoux method	* **			present on all physicals. If			
	administered by	-			signature is missing she will			
	documentation of	•			follow up with Corporate Medicine.3. What measures will			
		oved course of instruction			be put into place or what systemic changes will be made to ensure			
		berculin skin testing,						
	reading, and reco	ording unless a previously			that the deficient practice doe	es		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **OULM11** Facility ID:

000556

If continuation sheet

Page 79 of 81

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155747	A. BUI	LDING	00	07/22/20	
100747			B. WIN			01122120	711
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CE	NTFR	1300 MERCER AVE DECATUR, IN46733				
				ID	(V5)		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
	positive reaction	can be documented. the			not recur?IP #2 will check for		
	result shall be recorded in millimeters of induration with the date given, date read,				presence of physician signat		
					on the physical prior to filing.	Α	
	and by whom adı	_			form will be developed for tracking.4. How the corrective		
	und of whom dan	annistered.			action(s) will be monitored to		
	This state rule wa	as not met as evidenced			ensure the deficient practice		
	by:	as not met as evidenced			not recur, what quality assura programs will be put into place		
					IP, #1, will audit 5 physicals		
	Based on record	review and interview, the			month to ensure signature is		
		ensure 1 of 5 personnel			document. This will be done		
	_	ntained a signed physical			monthly times 6 months with		
	examination com	0 1 2			results to QA.		
		wed. (Employee #10)					
	Finding includes: During the review of personnel files, completed on 07/21/11 with Employee #12, the personnel file for Employee #10,						
	_	l, indicated the physical					
		not signed by the					
		written on the form was					
		al 07/16/10. no changes"					
	1 1 1	physicians signature on					
	the form.						
	Interview with E	mployee #12 confirmed					
		nurse practitioner					
		hysical had not signed					
	the physical exam						
	3.1-14(t)						

PRINTED: 08/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey Pleted 1/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		

000556